

**From Morningside to Muirhouse: Towards a
Local Governance of the Self in Drug Policy**

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Abstract

This dissertation presents an analysis of the evolution of drug policy that challenges the fundamental understanding of state power and its monopoly regarding drug problems. The research both maps the changing nature of drug control in Edinburgh and reassesses how and where this policy was formed. This analysis is grounded in empirical research gathered through interviews with policy formers, drug users, and support agency personnel together with documentary analysis of materials such as committee reports and minutes and other relevant journal articles and books. This empirical research has led to the development of, and provided evidence to support, two main theoretical assertions. First, the importance of policy formation at the local level is considerable and largely overlooked by the academic literature on drug policy formation. Secondly a new type of drug control strategy has emerged, parallel to older ones such as criminalisation, which may be termed as, borrowing from Michel Foucault, 'techniques of self-responsibilisation'.

The realisation of the importance of 'local governance' complicates our understanding of drug control. Policy formation becomes a problematized factor in deliberations on how and from where drugs are controlled. This research was designed to redress this important limitation. Governance here is not to be equated solely with government but can be exercised by any number of social bodies, departments, organisations and professional bodies, often with contingent rather than final results.

The second organising theme of this thesis is similarly designed to enhance understanding of the character and meaning of the social control of intravenous drug use. The study is intended to demonstrate that drug control policy has a diverse nature neither found in the exclusive embodiment of repression or liberation; nor exercised by a single agency or a sole representative within one. Social control here is divided into a deployment of techniques of the self, directed towards the transformation of the individual, and criminalisation, aimed at the repression of the individual drug user.

Chapter One discusses the literature surrounding these two organising themes drawing on work from within and without the criminological field.

Chapters Two (that includes a methodology) through to Four provide a detailed analysis of the evolution of intravenous drug policy in Edinburgh. The chapters are chronologically based on three distinct phases of the intravenous drug problem and policy. From a small problem in the seventies, through to the expansion of use and drug control in the eighties, the research finishes this triptych with an elaboration of policy in the age of AIDS and after.

The last chapter, Chapter Five, details the use of similar techniques of drug control in other jurisdictions. In addition, the idea of a network of trans-local governance linking together a number of European cities extends our understanding of developing sub-national arrangements concerning policy deployment outside, and sometimes in conflict with, the domain of national governments.

In conclusion, the dissertation argues that two relatively novel arguments have been advanced. First, that many aspects of drug control policy originate as distinctly local phenomena. Secondly that new practices have emerged that sought to enlist the assistance of the drug user rather than to imprison them and to transform their behaviour rather than restrict it.

DECLARATION

I declare that this thesis has been composed by me, and that the work is my own.

The work contained in this thesis has not been submitted for any other degree.

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INTRODUCTION

This dissertation is a criminological study concerning the way injecting drug use, such as of heroin, has been controlled in a major Scottish city and the manner in which policy change has occurred over time. Much has been written about broad change in criminal justice policy at a national and sometimes international comparative level. My research instead concentrates on the evolution of drugs policy at a more local level, namely within the city of Edinburgh over a period of three decades. This historical analysis is grounded through empirical research gathered through interviews with policy formers, drug users, and support agency personnel, and documentary analysis of materials such as committee reports and minutes, as well as local newspaper stories. This empirical research has led me to develop – and has provided evidence to support – two main theoretical assertions. First, the importance of policy formation at the local level is considerable and previously has been largely overlooked by the academic literature on drug policy formation. Secondly a new type of drug control strategy has emerged over the past decade, parallel to that of older ones such as criminalisation, which may be seen as based upon a number of (often conflicting) ideologies and practices, and including what criminologists writing in other areas, and borrowing from Michel Foucault, have termed as ‘techniques of self-responsibilisation’. The dissertation concludes by noting that some evidence to support these findings (that drug policy formation can be seen as emerging from local contexts, using similar techniques, as much as from central government) can also be found in other parts of Western Europe and elsewhere.

They do it differently in Midlothian

The central arguments advanced in this dissertation are therefore twofold. First what appear to be centralised governmental drug control policies have in fact often originally been initiated at a more local level. The assumption in much of the academic literature has been that control acts downwards and from the centre, but this assumption has tended to obscure a subtler reading of intravenous drug control policies in which control can be seen as emerging ‘at a local level’. By interviewing policy formers it has been possible to piece together how policy emerged and worked. This local emergence rather than being programmed into the policy system from

above, evolves and is generated from the ground up. Such emerging policies, which have an ‘unfinished’ and non-universal nature, upset the top-down power direction to which we are accustomed.

Such specification in contrast to a broader generalised approach inevitably invites counter-arguments regarding significance. Garland (2001, pvii), neatly for present purposes, alludes to this, by arguing that simply to acknowledge that ‘they do it differently in Midlothian’ is an inadequate way of dealing with the structural patterns and properties of a field of investigation even if these problems are often overcome by mutual revision within academic endeavour (Garland, 2001: x). However, if on the other hand, as this thesis contends, they not only do it differently in Midlothian, but that significant local policy formations have also emerged in Amsterdam, Frankfurt, Zurich, Sarajevo, and many other parts of Europe as well as the San Francisco Bay Area (to give just some examples) then we may need to rethink our assumptions both about how drug control policies originate and about whether it makes any sense to try to make national or international generalisations at the level of drug control policy *content*. This local perspective stands in contrast to those that rest on the idea that it is nation states that provide singular policy initiatives and competence in drug control. Indeed this new analytical framework implies that ‘UK drug policy’ does not in fact exist and rather that it is UK drug *policies* that more accurately reflect everyday reality. Lastly it is possible to identify some interesting and significant shared characteristics between cities in Europe and their approaches to drug control.

The second part of this thesis concentrates on what that change is. Far from the broader change from a culture of welfare to warfare, described by Garland (2001), with a punitive coda set in the basilica of the modern private prison of the United States, in Edinburgh at least there has been a contrasting move away from techniques of isolation to those of integration. It is the pragmatism of the streets, ‘local governance’, using Foucault’s phraseology, the technologies of the self, that have emerged as the most significant change in relation to the control of injected drug use. That this has happened at a time of broader contrary social and penal movement away from welfare heightens rather than diminishes the significance of this evolution. It must be stated though that such paradigm-like shifts are not in fact a sweeping away of one system, or set of institutions by another but rather a transposition of those

features. Similarly this thesis argues that what happened at the local level is more subtle than the termination of one policy paradigm by another, and rather that whilst emphasis may change, the local site remains a contested, complex, place.

This type of change has greater prominence and association in European contexts compared to those in the USA. In contrast to the populist punitive crime control measures in the USA, some of which have become culturally assimilated in the UK and elsewhere, as has been discussed by Garland (2001), comparisons in drugs policy suggests that policies in the UK are becoming increasingly divergent from those in the USA. As recently published governmental reports (Runciman Report; H.O.C. Select Committee on Home Affairs Third Report) reveal, there is an increasing tendency in the UK to follow local pragmatic responses in the UK and elsewhere in Europe rather than the ‘American position’ of the war on drugs.

‘Local Organisation’

The dissertation itself is organised into six chapters with the contents organised as follows. Chapter One introduces two existing approaches regarding the interpretative analysis of drug control policy. The first examined, which is dominant in the literature, assumes that the primary context for explaining changes in public policy is that of the state. Policy is perceived as an instrument of and as emanating from the central state that is then ‘trickled down’ to the local context. This view of policy power relations is often termed simply the ‘top-down’ approach. However, as is noted in later chapters, this does not seem to accurately reflect the way that drug control policy evolved in Edinburgh. Instead what became increasingly apparent was that significant developments in drug control appeared to be grounded in a local pattern of policy formation. Analysis of this everyday reality of policy formation has often, unsurprisingly, been termed as the ground or ‘bottom up’ approach. Chapter One then discusses some of the key ideas that explain and can characterise this local policy action. This includes examining how certain (post-Fordist) writers see wider political and economic change as weakening or ‘hollowing out’ the nation state’s power whilst international and local, sub-national, networks expand. The chapter argues that work by writers such as Foucault, studying power within local centres where its real effects are produced, can be appropriated and developed (Foucault, 1980a: 97). Following on

from this, other Foucauldian theories concerning concepts of self-responsibility, termed by Foucault as technologies of the self, are introduced in order to help characterise the emergent changes at the local level. Lastly the chapter reviews existing literature on drug control and the shortcomings of such approaches.

The next three chapters involve the substantive analysis of the formation and deployment of drug control policies in Edinburgh over the past three decades. As such these establish the empirical evidence for the two main arguments being advanced.

Chapter Two opens with a discussion of how the empirical research was conducted. The chapter then establishes the nature of the drugs scene in the late 1960s and early - 1970s and the drug control policies then in place. Detailed discussion of the drugs market and the treatment, policing and resistance by drug users to these policies provides the point of contrast for what followed. Importantly there are two other issues that should be noted within this chapter. First it is noted that even at this early stage policy was often initiated and determined at a local level by those involved within the city. Secondly it is argued that from the start there were a range of policy responses and that the local site, the everyday reality of drug control policy in Edinburgh, was contested and often quite divergent in nature.

Chapter Three first shows the defining change in the local drugs scene. The characteristics of the first real heroin epidemic in Edinburgh in 1980 provides the context through which subsequent policy reaction is viewed. The chapter then goes on to analyse the expansion of local policy action. It details how these often *ad hoc* community initiatives grew from the ground up forming local centres of power attempting to control drug use on and from the streets. Examination of national level reports further confirms this. Analysis within this chapter also shows another definitive movement in policy, namely the emergence of new ways of attempting to control heroin use, which I characterise as involving techniques of self-responsibilisation, together with the intensification of older ones, namely criminalisation. This combined latter argument again reiterates the contested nature of the local policy site.

Chapter Four enhances and reinforces the argument that change emerges from below. It starts by detailing the second epidemic that affected injected drug use policy, namely that of HIV/AIDS. The chapter shows how the tragic rates of infection in Edinburgh prompted the development of an exemplar model of response. This reaction illustrated the strength of local relevance in policy-making paving the way to a similar national-level response. Additionally the emergent strategies of responsibilisation of the self became not only increasingly dominant in terms of priority but diversified and elaborated, to techniques of the safer self, to deal with this different crisis.

Chapter Five argues that the specific case of Edinburgh is far from unique. Local governments, police forces, criminal justice agencies, and welfare groups can be shown to be involved in drug control policy formation in various different parts of Europe. The formation of what has become known as the 'Amsterdam Model' (a far from punitive approach) has proved a highly influential model, and, having been developed within that Dutch city, has been widely copied by a number of other European cities. Such an example provides greater comparative depth to both the argument over the direction of control flows and divergence from a punitive driven culture of crime response. The city level adoption of this approach, contained in a document signed by over thirty European cities in nine different countries called the Frankfurt Resolution (1990), not only provides a challenging contrast to the traditional multi-state Europeanised drug policies but defies the legitimacy or the appropriateness of the content of policies that ignore the local or city level. This competence-challenging innovation, with its trans-local linkages, develops another transposition where the role of local governance is no longer perceived solely in terms of the relationship with the nation state, but in the development of trans-local relationships with other regions or cities.

The dissertation ends with a summary of the research findings of the preceding chapters and concludes that policy can and does emerge from local centres of power. It is argued that the evidence supports the hypothesis that the dominant mode of accounting for drugs policy development (namely that it is developed and implemented principally by central government) does not appear accurately to describe the actual formation of drugs policy in the City of Edinburgh over the past

three decades. It is argued that the alternative model of policy formation, developed over the course of the dissertation, provides a better and more compelling account as to the nature of drugs policy formation.

CHAPTER 1

Local Approaches to Policy Formation and Drug Control

The discussion in this chapter focuses on two themes. The first topic concerns the location or level of policy formation. Focusing on works by Paul Rock (1986; 1990; 1994; 1995), the opening section provides an examination of the top-down approach to criminal justice policy analysis. After discussing work that has implicitly questioned the dominance of this analysis the discussion opens outwards to introduce work from other disciplines which has developed notions of a local level that question top-down, state-centred, dominance. Whilst Handler (1996) discusses the local site as a process of de-centralisation other commentators, such as Jessop (1997) and Mayer (1995), view sub-national development as part of a wider structural, post-Fordist, nature resulting in a diminishing state role. Following this, work by writers such as Foucault (1979a, 1980a and 1982) will be analysed to demonstrate the theories of power within local centres that will be appropriated and developed within the chapters that follow. This examination of the 'local Foucault' will include an acknowledgement that this is not an uncontested interpretation.

The second theme of this chapter is that of emergent changes in the type of drug control. Drawing from Foucault, and writers who have been informed by his work, theories of 'self-responsibilisation' will be analysed in order to show how these emergent techniques of control can be characterised. This theme will be developed in following chapters, where it will be argued that the reliance on such techniques within recent drug control policies constitute a significant development. The chapter will conclude with reflection on how, and indeed the extent to which, these two themes have so far been represented - within criminological literature and drug control.

Paul Rock and Criminal Justice Policy Formation

One of the more detailed accounts of the criminal justice policy-making process is that contained in the work of Paul Rock. Rock's works (1986; 1990; 1994; 1995) provide a complex analysis of policy formation. In the first work Rock describes the focus of analysis as being:

Upon all that complicated interplay between the initiative, its authors, and the social arenas in which it was produced. In a sense it will investigate the growth of a portion of reality (Rock, 1986: 2).

Rock examined how the growth of the Victims Crime Initiative policy in Canada was encouraged through an intricate negotiation between diverse networks including-political officials, moral entrepreneurs, ministry and related staff, pressure groups and the police. This work furnishes a detailed analysis of the often contingent policy construction within a central state bureaucratic organisation, together with the interaction with other concerned agencies. Rock in addition provides a personal dimension with the identification and study of certain officials who came symbolically to 'own' the project. The biography of these moral entrepreneurs provided the locus of the policy-making initiative and the networks that subsequently surrounded it.

In *Helping Victims of Crime*, Rock (1990) reconstructs the emergence of victim support schemes in the UK and their eventual adoption and funding by the Home Office to the (by then national) victims organisation. The description of the evolution of the victim support movement and policy, moves between detailed analysis within the local origins of the victims organisation and Home Office deliberations. Through a detailed insider biography, Rock tacks back and forth between the local and the national level groups. Seemingly because of the subject matter, this second book represents agency formation as being more heavily located at a local organisational level. However both books share a common perspective on policy as being one that originates at a national level, with central government making the decision to adopt and underwrite policy. This would seem wholly appropriate when analysing national agencies.

Rock's more recent work (1995) focuses generally on a number of 'small structures and processes' said to be the engine of routine politics and policy making in criminal justice. Rock again alludes to the often individual nature of policy trajectory as being one of 'bottom-up' moving from officials to ministers. He acknowledges that the origins of these ideas may well have been rather distant from senior governmental offices:

In instances of bottom-up policy making, the setting where new ideas were engendered may well be structurally distant from the settings in which they will be inspected and approved by senior officials or politicians (Rock, 1995: 5).

However the chief instrument in criminal justice policy making, identified by Rock, is that of the committee:

Seminars, surveys, literature reviews, and fieldwork supply the criminologist's knowledge, but it is the committee that chiefly supplies the knowledge and methodology of policy makers and politicians. Committees are the stock of government (Rock, 1995: 8).

For Rock, policy emanates from a central core, being centrally diffused, in a dialectical process which refers to larger groups and becomes increasingly anonymous:

The whole amounts to a dialectic in which policies enter the public domain step by step, being sent out to ever-wider social circles and presented for possible acquisition, and returning each time transformed (Rock, 1995: 14).

An earlier piece (Rock, 1994) concerns the constitution of a small central government 'policy community' and the programme development it established. Again local policy participation and relevance is characterised by Rock as one that is limited to that of reaction. There was little original input from the local level in policy generation.

In the topics Rock examines, this type of descriptive analysis seems both accurate and relevant. The methods used provide a detailed picture of the 'realistic' evolution of a specific policy together with a detailed checklist of markers for rendering a similar future realism to policy analysis. The overall representation of policy making perceived within these works is neatly summed up in one of Rock's conclusions:

Policy making is the instrument through which the original, subjective inspiration of a few individuals closeted within a bureaucracy can move out to become a public, anonymous, and objective component of the criminal justice system at large (Rock, 1995: 16).

Policy, as described by Rock, is 'translated'¹ and charged from the centre and discharged into what surrounds it. What surrounds it - pressure groups, institutions and other organised bodies - can influence policy through, for example, input in the planning and implementation of the programme. The practice a particular agency may also influence policy if it is seen as good practice as in the case of certain police forces in Rock's Canadian study. However the surroundings can influence policy only in relation to the centre. The geography of the obligatory point of passage for policy is firmly located in the relevant State ministry. The ministry responsible acts as a determinant and conduit for these 'outside' influences. Thus when Rock talks of 'bottom-up' policy, this is a very narrow conception that refers only to the subservience of government civil servants towards their ministers. The concerns of policy-making in Rock's depiction may be described as being implicitly referential towards those ideas that were transformed into state policy and legislation. In essence then, for Rock the trajectory of policy may be seen as one in which policy tends to emerge or be enacted in the first instance from the top, and that although such policy may subsequently be adopted or adapted by wider institutions, nevertheless in terms of policy origination Rock's work can be characterised in terms of it being 'top-down' in both its political location and outcome.

The methods used of tracing policy formation through individual or biographical networks represents a powerful account of criminal justice initiatives. However, it must be remembered that Rock purports to represent certain events and relations within particular justice policy 'histories'. The importance of the methods used for the purpose of his research remains uncontested. Rather it is the importance of the location of the agency in policy formation that is disputed. Rock's work is not explicitly a study of top-down policy formation. However, the way that policy formation is consistently characterised is very much in the nature of a statist approach.

¹ For a fuller description of the term 'translation' borrowed from the writings of Bruno Latour and Michel Callon see Callon et al (1986).

As will be shown in the following chapters 'real' policy formation in drug control exists and is dominant at a local or city level. Rock's neat, if intricate, 'statist' explanations of power and policy formation are not adequate to the study of policies relating to the control of drugs examined in this research. Indeed the sub-national approach subverts Rock's model of policy analysis in two related ways. First, it inverts the importance of centrally diffused statist policy, from the top-down, instead positing the importance of analysis from the ground up. Secondly it challenges the predominance of government departmental bureaucracy in the formation of criminal justice issues of policy and control. Instead of engaging in the pursuit of the inside view of government policy, the research will offer a perspective based upon local governance.

Rock's work raises important intellectual questions surrounding the site of policy making. Within criminology, David Garland (1996) in his article 'The Limits of the Sovereign State' addresses a perceived change in the location of practical action in criminal justice policy since the mid-1970s (1996: 450-451). He notes the expansion of services provided '*beyond* the state apparatus' and argues that the state's recognised limited capacity led to solutions being sought in the 'everyday life world to bring about change' (1996: 451). Whilst still adhering to a centralist position, akin to Rose (1993)- (discussed later in this chapter), of power in the last instance being controlled by the development of strategies of governance-at-a-distance (1996: 454) the problematical relationship between changing sites of power and policy formation is clearly implied. This has been further discussed in recent works by Adam Crawford which focus on notions of community and partnership in crime prevention (Crawford, 1997: 1998). Whilst Crawford warns that there is a danger of over-emphasis regarding the breach that these trends represent (Crawford, 1997: 233) he nevertheless perceives policy in a more subtle light, neither entirely 'upward' nor 'downward':

There is no unidirectional tendency, but a plurality of tendencies. The central state's capacity in some spheres of operation is being diminished, in others it is being intensified, and in others it is being refashioned (Crawford, 1997: 223).

The direction from which policy emerges then is perceived as being unsettled and contingent. The trajectory of this formation is depicted as subject to discovery

depending on the sphere of policy analysed. While these local sites have always existed their importance in other academic fields, discussed later in this chapter, is becoming increasingly accentuated. Whilst the discussion that immediately follows ranges from the local to the global the central analytical theme surrounds the destabilisation of the state as a universal unopposed centre of policy formation and the development of alternative sites of power, including the local. Its purpose is to highlight the broader negotiation or re-negotiation of the boundaries of power and policy making. The relevance of this can clearly be perceived when positioning the reality of bottom-up policy formation within wider debates on the direction of and approaches to sites of power. This provides a deeper contextual analysis of policy evolution when discussing for example the importance of the growth of local non-governmental organisations (NGOs) and their impact on drug policy formation within Edinburgh. The significance of this evolution would be measured, from a statist perspective, only in terms of its implementation of central policy. However, looked at from the alternate viewpoint it can be assessed as part of a growing development in the re-location of drug policy initiative and formation. That local governance is arguably expanding not only in drug policy but as part of a broader movement within social policy as a whole provides an important emergent theme not just for this thesis, but for studies of criminal justice policy in particular and social policy in general.

To do this it will be necessary to elaborate both on studies concerned with the changing emphasis in the site of power and on theories of power. This first mentioned has been the subject of many debates within subjects ranging from political science to urban studies and related disciplines. The discussion and elaboration of the central themes of this research will provide the context within which the location of policy formation can be re-evaluated in the light of the description of drug control evolution which follows.

De-centralization and the local level 'Down Below'

What follows is a review of two perspectives which will inform a reappraisal of the importance of the local level. The first of these, developed by Handler (1996) discusses the process of de-centralisation of authority in the US, while the second

perspective is that of regulation theorists such as Jessop and Mayer (1997: 1995) who develop a post-Fordist model that draws attention to the changing nature of the state and the development of alternative sites of policy competence.

Joel Handler (1996) makes the following statement concerning his book's central preoccupation:

The thesis of this book is that decentralization - the deliberate allocation of authority to lower bureaucratic units, whether public or private - is a major technique for managing conflict (Handler, 1996: 10).

Perhaps the central other theme running through his book is the representation of the importance that the local context has for the 'actual delivery of public policy' (Handler, 1996: 11)². He questions the distinction drawn between the public and the private in an age increasingly dominated by intra-governmental contracting and where non-governmental organisations (NGOs) become responsible for public business. He perceives issues surrounding decentralization as more importantly about 'governance, the allocation of power in society, and the management of public problems' (Handler, 1996: 8).

Handler remains keen throughout to point out the centrality of the local context:

From the description so far, one might get the impression that the responsible federal granting agency is merely an inert dispenser of funds, caught in a buffeting sea of interests. To some extent, it is valid to emphasize this complex content, if only to correct the traditional simplified version of an active, purposive, effective single centralizing federal government speaking with one voice. The granting agency, the legal and administrative structure of the program, and the funding are of importance; but they are variables rather than fixed determinates (Handler, 1996: 29).

Further on, even after considering centralising factors and processes, Handler remains unequivocal:

However, none of the centralizing tendencies lessens the importance of looking at implementation at the field level. The central, overarching fact is decentralization, the presence

²Whilst there are many differences between the US and UK political systems Handler's discussion of de-centralisation and the local level touch upon common concerns about governance power, and the management of social problems.

of widespread discretion at the local level, the decisiveness of the local units in the implementation process. Discretion is bounded by its environment, and that environment includes local, state, federal, and private influences. Nonetheless, the most important sources of influence operate at the local level (Handler, 1996: 39).

Handler's explanation of events centres around the drastic reduction of direct federal funding to cities under the Reagan presidency forcing local governments to raise local taxes, reduce services and contract out (Handler, 1996: 66-67). This forced decentralisation unexpectedly resulted in a situation where:

Local governments not only spend more than state governments, but also employ more people; they are now the primary public service provider...In many areas of the social welfare state, energy and initiative is more now at the state and local level, and, although state governments have grown in importance, cities and localities are even more significant than ever in the actual delivery of services (Handler, 1996: 67).

Handler also contends that in issues surrounding social consumption or welfare, decentralization becomes a political tool of the central legislature whereby responsibility is devolved over controversial decisions whilst allowing symbolic credit for any successes (Handler, 1996: 43).

To accept this point is not necessarily to see the local level as 'superior' to central government. Richard Briffault, for example, strongly asserts that local control in the US as regards education and housing can lead towards, as he terms it, a 'localism' that is heavily implicated in preserving class and race segregation and obstructing issues of social justice:

The virtues of enhancing local autonomy tend to be greatly exaggerated. Localism reflects territorial economic and social inequalities and reinforces them with political power. Its benefits accrue primarily to a minority of affluent localities, to the detriment of other communities and to the system of local government as a whole. Moreover, localism is primarily centred on the affirmation of private values. Localist ideology and local political action tend not to build up public life, but rather contribute to the pervasive privatism that is the hallmark of contemporary American politics. Localism may be more of an obstacle to achieving social justice and the development of public life than a prescription for their attainment (Briffault, 1990: 1-2).

Thus it would seem to be the case both that local control may have detrimental effects in particular circumstances, in relation to housing and school zoning in the US, and that local issues are not the property of any one political perspective whether of the 'left' or 'right' (see also Handler, 1996: 216).

It seems at first that Handler has put the local context at the forefront of policy studies. However, the limitation of this model is revealed by the wording in his statement that 'the decisiveness of the local units in the implementation process' that indicates a lack of involvement in policy formation. This ring-fenced definition seems at odds with the portrayal of a fluid, malleable, system of governance where city/NGO providers have been one of the biggest growth areas in the economy. Handler seems simultaneously to acknowledge local discretion, vague central mandate and ineffectual monitoring (Handler, 1996: 38) and deny the presence of any local experience or local impact upon policy. This strict dichotomy seemingly rules out any real investigation of ad hoc endeavour and elaboration regarding responses to social problems down below.

Down with the State: Post-Fordism and the sub-national

Whilst regulation theorists direct most of their attention to economic policy they do provide a backdrop to the growth in importance of the city-level being the result of deep structural change revolving around the notions of globalisation and post-Fordism. Policy formation at the sub-national level is part of the process of a changing and reduced role for the nation state.

There are roughly four main characteristics commonly given when describing post-Fordism³. The first feature is that the process of production, increasingly based upon microprocessors and information and communication technologies, facilitates increased flexibility within mass production assembly lines or indeed their replacement by more specialised production processes (see generally Jessop, 1997: 257-260). Secondly the patterns of accumulation changes from one based on economies of scale and long runs of identical products, to one based on economies of scope, and the flexible, innovative diversified production of goods. Thirdly, social relations within production change to localised bargaining and a flatter hierarchy. Lastly, there remains as yet no one single model of 'societalisation' comparable to the

³For a detailed exposition on the characteristics of post-Fordism see Jessop 1997 and Mayer 1995: 247, note 2

Americanisation model associated with the Fordist era. Competing Japanese, German and American models have yet to be realised as the stable post-Fordist society.

Whilst the focus remains at a macro level (Jessop, 1995), this vision of economic restructure produces a different state form from that of the Keynesian welfare system. This 'Schumpeterian workfare state', as Jessop (1997: 253) terms it, reflects the state's changed terms of intervention. The state intervenes on the supply side by encouraging competitiveness whilst subordinating social policy to the needs of a flexible labour market. Such collective notions as full employment and the redistribution of wealth through welfare become seen as both impractical and undesirable in an age where learning skills to attain goals are more heavily emphasised. The state faces a 'competency strain' both from multi-nationals which can locate anywhere without consultation, and from 'world cities' which monopolise concentration of certain services and head offices (Le Gales and Harding, 1998). Jessop outlines the implications for national policy/autonomy as follows:

This loss of autonomy creates in turn both the need for supranational coordination and the space for subnational resurgence. Some state capacities are transferred to a growing number of pan-regional, plurinational, or international bodies with a widening range of powers; others are devolved to restructured local or regional levels of governance in the national state; and yet others are being usurped by emerging horizontal networks of power - local and regional - which by-pass central states and connect localities or regions in several nations (Jessop, 1997: 264).

The first aspect of the 'hollowing out' of the national state (Jessop, 1997: 264) has been the exponential growth and remit of supranational competencies. The EU, NAFTA, NATO, IMF, and WTO not only regulate international trade and relations but can drive, limit or direct national policies. Contrary to Handler's analysis, the sub-national level not only includes power that is deregulated, but also power that is usurped or seized, implying formation as well as implementation.

Margit Mayer (1992; 1995; 1997) attempts to identify the emergent changes and structure of an urban governance. Noting the intensification of social/spatial polarisation, detailed elsewhere by Davis (1990), within and between regions and cities Mayer explores a shift in emphasis between levels of policy fields. When

discussing European policy developments in the local welfare state Mayer partially echoes Handler in her description of evolving changes:

A qualitative restructuring has taken place, involving an increase in the relative importance of non-state (private and voluntary-sector) organisations or of public agencies directed by market criteria (quasi-governmental agencies) in the provision of various services....This 'privatisation' means that instead of providing public services directly, local governments increasingly oversee and regulate other agencies who provide the actual services. Thus, in the sphere of service provision...hierarchical, public-sector-led forms of management have been scaled down and/or replaced by a diversity of private, semi-public and voluntary agencies and initiatives, and parallel needs for co-ordinating structures have emerged (Mayer, 1992: 260).

A new realm of local political action develops with an enlarged non-governmental 'third sector' and a public sector that readjusts, moving towards a role that emphasises enabling co-operative policy innovations (Mayer, 1995: 241).

Critics, such as Harding (1996, 1997), worry about the power of local elites (much like Briffault), and argue that either these processes existed before or that not enough empirical research has been completed. Either way, Harding insists, little can happen without the involvement of the nation state (1997: 308). However John and Cole (1998) have identified some empirical evidence of city-level decision making structures or 'urban regimes' in the cities of Leeds and Lille. These sustained, inter-organisational, co-ordinated decision-making regimes develop along local public/private horizontal axes.

A third and related trend towards policy formation and the hollowed-out state has been identified as the growth towards trans-local linkages. Jessop sees this development as being symptomatic of a redefinition amongst some local agencies which no longer perceive their role within purely national boundaries but instead seek relationships of a trans-national nature (Jessop, 1997: 273-274). These connections may be of a vertical nature between cities and say the European Union, or horizontal as between various certain metropolitan regions in Japan and East Asia. Trans-local policy formation will be explored in greater depth in the Chapter Five. For now it remains a challenging framework for the study of an internationalised city-level policy formation that essentially bypasses state level authority. The argument surrounding

local policy has offered a distinct approach to traditional state centred assumptions concerning the top-down direction of social policy.

This idea of contrasting levels of analysis is further reinforced by some of Foucault's writings on what might loosely be termed methodology or investigative precautions. Foucault hints through a number of methodological directives that the study of power relations, and hence the composition of governance, should begin at the point where power is directly applied. This points towards the study of local centres and formations as the proper one within which to study power. It is these ideas of a 'local governance' that will now be examined, in order later to inform analysis of drug control in subsequent chapters.

The 'Local Foucault' and Local Governance

At certain points in Foucault's later works there is a seemingly clearly expressed emphasis on the importance of studying power at the local site or centre. In his 'Two Lectures' (1980a) Foucault's expression of this local analysis can be seen:

It should be concerned with power at its extremities...with those points where it becomes capillary, that is, in its more regional and local forms and institutions....it is a case of studying power at the point where its intention, if it has one, is completely invested in its real and effective practices. What is needed is a study of power...at the point where it is in direct and immediate relationship with that which we can provisionally call its object, its target, its field of application, there – that is to say – where it installs itself and produces its real effects (Foucault, 1980a: 96-97).

This assertion of the local recurs again in another work 'The Subject and Power' (1982):

Power exists only when it is put into action, even if, of course, it is integrated into a disparate field of possibilities brought to bear upon permanent structures (Foucault, 1982: 788).

This immediate or local nature of study is further reinforced in part of the later writing on method contained in the first volume of 'The History of Sexuality' (1979a). Here, Foucault talks directly of understanding power through the investigation of local centres of power. In his work, he sets out the ways of investigating power and how governance is deployed. His first rule is the rule of immanence and has the most

significance for study of the local in that this rule specifically directs out attention to the micropolitics of power:

We will start, therefore, from what might be called 'local centres' of power-knowledge: for example, the relations that obtain between penitents and confessors, or the faithful and the directors of conscience (Foucault, 1979a: 98).

Foucault signals the importance of studying power at the level of policy aimed at the individual or localised group and argues that this is of equal importance functionally and theoretically as analysis of broader levels of management. Indeed at certain points Foucault seemingly inverts the trajectory of the study of power perceiving it as emanating from the local 'upwards':

The important thing is not to attempt some kind of deduction of power starting from its centre and aimed at the discovery of the extent to which it permeates into the base, of the degree to which it reproduces itself down to and including the most molecular elements of society. One must rather conduct an *ascending* analysis of power, starting, that is, from its infinitesimal mechanisms, which each have their own history, their own trajectory, their own techniques and tactics, and then see how these mechanisms of power have been – and continue to be – invested, colonised, utilised, involuted, transformed, displaced, extended etc., by ever more general mechanisms and by forms of global domination (Foucault, 1980a: 99; emphasis in original).

Again in 'The Confession of the Flesh' (Foucault, 1980b) Foucault speaks of the need to look at how the greater strategies of power *depend* on the local, micro-relations, of power (1980b: 199).

However Foucault's trajectory ascending to ever more general and global sites has encountered some criticism for its dilution of initial emphasis. Lois McNay (1992) sees this specific passage, above, as evidence suggesting an undermining of local centres of power:

Foucault frequently stresses the insidious capacity of forms of global domination to invest and annex even the most oppositional microstrategies of power (McNay, 1992: 179-180).

Furthermore, Wickham detects an essentialist air about this seeming global culmination:

Foucault is wrong to argue that some sites of power relations, the micro sites, are incorporated into global sites, defined in terms of global strategies. This formulation suggests, very strongly, that these global sites exist as essences, which can be studied as such with the proviso that they

be read as having been formed from the bottom up rather than the top down (Wickham, 1983: 481).

What seemingly lies at the heart of these concerns is a re-location of the study and source of power by default. To settle this conclusively could be seen as being in the nature of forcing an answer for its own sake. What can be said is that Foucault certainly develops and positions the initial investigation of power at a local level. Secondly, for Foucault, the ground-up analysis remains a significant, and arguably, dominant reading of power relations. For whilst Foucault assumes a vertical rather than horizontal movement, as in the case of trans-local policy formation, the initial evolution is one grounded in the local centres. Perhaps the best balance is to be found in Burchell's (1993: 268-269) proposition, that neither the local nor the more general level can assume an irreducibility of one to the other or even a harmony, but that empirical case analysis alone should uncover the nature of this relationship, if any.

Of Governance, Governmentality and the State

Various interpretations of Foucault's work on governance have attempted to elaborate these theories in relation to the modern liberal state. Of the most notable are those writers on the sociology of governance among whom Rose is prominent. Rose utilises concepts from Foucault to offer two distinct notions of government namely those of governance and governmentality:

The ethos of analytics of governmentality is very different from that of sociologies of governance. First, analyses of governmentalities are empirical but not realist. They are not studies of the actual organization and operation of systems of rule, of the relations that obtain....they are studies of a particular 'stratum' of knowing and acting. Of the emergence of particular 'regimes of truth'...ways of speaking the truth (Rose, 1999: 19).

For Rose *governmentality* eschews study of sociological realism (Rose, 1993: 288) and the operation of systems, be they the state or local agencies, in favour of a study of the *mentality* of rule (1993: 288). It is from the study of mentalities or regimes of truth that Rose adapts the term 'government at a distance'. The location of power, of decision-making, is situated in these ways of thinking or problematizing. This means that the modes of social intervention are transmitted through the ways problems are

known and transpose themselves onto other persons. In terms of the location of power the state government becomes rather nominal in this more abstract system of analysis.

However this approach to the location of power has come in for some criticism. Notably, Garland's (1997: 199-201) analysis focuses on the omission of any practical assessment of the way that these rationalities are used:

There is a need to study the way that these knowledges and techniques are put to use, and the meanings they acquire in context...In other words, there is a tendency to use historical materials *philosophically* to demonstrate that there are different ways of knowing, rather than asking, as a sociologist or historian might, 'how did these things function?' and what did these things mean? (Garland, 1997: 199).

Garland makes the point that the study of these, rather perfected and fully formed, abstractions does not represent the end of an examination but rather one interrogatory stage 'in the process of empirical analysis' (1997: 199). He rejects the dismissal of realism not only on the grounds that practical application should not be ignored but that these 'knowledges' are often not employed in a straightforward manner:

It becomes essential to explore the real practices and processes in which these programmes and rationalities and technologies are selectively and sometimes unexpectedly used, with all of their compromise formations and unintended effects (Garland, 1997: 200).

For Garland the greatest effort should be made to establish the connection between how agencies actually come to understand and manage a problem and the forms of power-knowledge and technologies that are used in these interventions (1997: 200). There is within this sociology of governmentality, Garland asserts, no way that this type of connection can be made, as the study of ways of thinking assumes that the location of all power exists outside the realm of agencies in an abstract form. Instead of a (Foucauldian) history of systems of thought, Garland advocates a more 'grounded analysis' that includes the examination of a policy area as it operates and is experienced by those in it. Not to do so, according to Garland, is to ignore the often dynamic situation of policy formation in favour of a presentation that relies on a singular, static, form of thought.

Furthermore Rose is vulnerable to Wickham's (1983) charge of analysing its object in terms of an all-important essence that lies always and already outside. Non-essentialist analysis should focus instead on 'practices', where:

By 'practices' here I mean more than institutionally constrained actions and I mean more than something which is outside knowledge. By practices here I mean common groupings of techniques and discourses (Wickham, 1983: 480).

Going further than Garland's unexpected uses and compromised formations, there is the very real possibility that far from being a source of alteration or supplementation local sites play a more important role in the formation of power.

The following section lays the foundations for the analysis of the ways policy has sought to control drugs. One of the more subtle theories of social control has been associated with Foucault's studies of power. These concepts and their further elaboration by other writers will heavily inform the discussion of drug control policy in Edinburgh. Particular emphasis will be placed upon Foucault's discussion of types of control that seek to work through self-responsibilisation, which he called technologies of the self. It is argued that these technologies best characterised emergent changes in the types of control utilised and analysed in later chapters.

Measures of Control: Domination and the Self

In his article 'Technologies of The Self' Michel Foucault (1988a) describes the techniques by which individuals have been compelled to decipher themselves in regards to what has been forbidden. Foucault has described these 'technologies' as:

Technologies of power, which determine the conduct of individuals and submit them to certain ends or domination, an objectivizing of the subject. Technologies of the self, which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conducts and the way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or morality (Foucault, 1988a: 18).

These two technologies, called elsewhere by Foucault domination and the self, are the most central in the management of individuals and populations alike:

This contact between technologies of domination of others and those of the self I call governmentality (Foucault, 1988a: 19).

Techniques of domination

The techniques of power/domination evolve in two basic forms. The first technique was the discipline of the body that involved:

Methods, which made possible the meticulous control of operations of the body, which assured the constant subjection of its forces and imposed upon them a relation of docility-utility, [which] might be called 'disciplines' (Foucault, 1977: 137).

Foucault distinguishes this disciplinary control from asceticism, associated with the monastic type (see Foucault, 1977: 137). The 'disciplines' of the monastery were aimed primarily at control over the individual body or, as we shall see later, 'the self'.

The second form that these technologies assumed was focused on the body at the level of the species. Management of the population in terms of its propagation, mortality, level of health and all the conditions that caused variance was effected through 'interventions and *regulatory controls: a bio-politics of the population*' (see Foucault, 1979a: 139). These combined technologies become enmeshed in institutions such as universities, hospitals, secondary schools, barracks, prisons and factory workshops and discourses surrounding birth-rate, public health, housing and migration. This extrapponential growth of techniques of controlling the individual and social body Foucault refers to as 'bio-power'. The links between this bio-power and the development of production/industrial capitalism Foucault describes as follows:

This bio-power was without question an indispensable element in the development of capitalism; the latter would not have been possible without the controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to economic processes...If the development of the great instruments of state, as *institutions* of power, ensured the maintenance of production relations, the rudiments of anatomo- and bio-politics, created in the eighteenth century as *techniques* of power present at every level of the social body and utilized by very diverse institutions..., operated in the sphere of economic processes, their development, and the forces working to sustain them. They also acted as factors of segregation and social hierarchization,... guaranteeing relations of domination and effects of hegemony (Foucault, 1979a: 140-141).

This connection between technologies of control and political/economic processes is a more subtle analysis than those marked by an examination of more 'traditional' types

of domination, often supervised directly by the state. Traditional domination comes in the form described by Rose as:

[indicating] a particular node of operation of power...It is a mode of acting upon individuals or groups of individuals directly *counter to their aspirations or demands*. (Rose, 1992: 2, emphasis added).

This type of domination is more closely associated with Foucault's notion of Sovereign Law, criminalization and its agencies of control. Rose and Valverde (1998) briefly assess the modern standing of the 'instruments of law' (such as legal codes and laws) compared to the explanatory power of technologies of domination. The authors suggest that juridically imposed rules of law are still of analytical importance but this assessment is tempered by the belief that new extra-legal processes and practices undercut law's privilege (Rose and Valverde, 1998: 546). Additionally technologies of the self provide a second dimension of control beyond law.

Technologies of the Self

By telling or 'verbalizing' thoughts to a director these techniques allow active discrimination as to the quality of thoughts, interpreted through the confessional relationship as Foucault explains:

Confession permits the master to know because of his greater experience and wisdom and therefore to give better advice. Even if the master, in his role as a discriminatory power, doesn't say anything, the fact that the thought has been expressed will have an effect of discrimination (Foucault, 1988a: 47).

Foucault described these technologies in their early Christian form (Foucault, 1988a: 48) whilst briefly acknowledging that these technologies have undergone important changes:

From the 18th century to the present, the techniques of verbalization have been reinserted in a different context by the so-called human sciences in order to use them without renunciation of the self but to constitute, positively a new self. To use these techniques without renouncing oneself constitutes a decisive break (Foucault, 1988a: 49).

The Further Elaboration of The Self

It is these technologies of control of the self that Nikolas Rose has examined in their latest historical elaborations. Although not altogether a 'Foucauldian writer', Rose seeks (by analysing the techniques deployed by therapeutic treatment and other 'psy' sciences) to establish a more contemporary history of the 'government of subjectivity'. This form of control, he asserts, has become central and essential to modern governance:

Incorporating, shaping, channelling, and enhancing subjectivity have been intrinsic to the operations of government. But while governing society has come to require governing subjectivity, this has not been achieved through the growth of an omnipotent and omniscient central state whose agents institute a perpetual surveillance and control over all its subjects. Rather, government of subjectivity has taken shape through the proliferation of a complex and heterogeneous assemblage of technologies. These have acted as relays, bringing the varied ambitions of political, scientific, philanthropic, and professional authorities into alignment with the ideals and aspirations of individuals, with the selves each of us want to be (Rose, 1990: 213).

This analysis is concerned not with the expansion of Foucault's notion of domination but with that of the self. Whilst Rose acknowledges that behaviour therapy has a 'hard' or 'crude' end, this is not his major point of focus. As Rose explains,

To take exception to this 'hard' end of behavioural techniques would be to miss the point. For these ways of thinking and acting have gained much broader purchase upon our reality. From giving up smoking to the management of anxiety, from sex therapy to assertion training, from reformation of the kleptomaniac to cognitive restructuring to change values, from prison workshops to management training courses, indeed wherever particular forms of human conduct can be specified and are desired, behavioural techniques may be deployed. These techniques...provide a way of promoting the capacity to cope in accordance with social norms among new sectors of the population and in new institutional sites (Rose, 1990: 237).

This type of control is more than crude moral restraint. It is a management to produce a desired transformation of conduct through a complimentary therapist/client relationship:

The therapist instructs the 'client' in the rationale of the technique, but, more important, educates him or her in the means of self-inspection to be used; systematic self-monitoring and record keeping, showing the occasions on which desired and undesired behaviour occur, and the construction of a detailed plan programme for transforming conduct, not through airy and ambitious hopes, but through little steps, with achievable goals, each followed by rewards (Rose, 1990: 237).

Secondly these techniques become ascribed not as enforced conformity but as a project of (self) responsibility replacing discourses of disease/treatment with education/skills (see 1990: 238):

It is easily transformed into a technique of self-analysis and self-help, a therapy of normality to enable us all to cope with stress, anxiety or demanding social situations, into a pathway to asserting ourselves. It is thus entirely consonant with a secular ethic of the technical perfection of lifestyle by the autonomous and responsible self. For it now becomes possible to think of all forms of social behaviour, successful and unsuccessful, not as expressions of some inner quality of the soul, but as learned techniques or social skills. And what is learned can be relearned (Rose, 1990: 237).

Additionally, not only can these techniques of autonomy be relearned, but also they become a constant source of self-surveillance:

They institute, as the other side of their promise of autonomy and success, a constant self-doubt, a constant scrutiny and evaluation of how one performs, the construction of one's personal part in social existence as something to be calibrated and judged in its minute particulars. Even pleasure has become a form of work to be accomplished with the aid of professional expertise and under the aegis of scientifically codified knowledge (Rose, 1990: 239).

These technologies for the management of the self are not then aimed at establishing collective conformity to any set of meta-principles. They are instead focused on providing the means by which the self may acquire skills to make personal decisions and assume personal responsibility:

The self it seeks to liberate or restore is the entity able to steer its individual path through life by means of the act of personal decision and the assumption of personal responsibility. It is the self freed from all moral obligations but the obligation to construct a life of its own choosing, a life in which it realizes itself. Life is to be measured by the standards of personal fulfilment rather than community welfare or moral fidelity, given purpose through the accumulation of choices and experiences, the accretion of personal pleasures, the triumphs and tragedies of love, sex, and happiness (Rose, 1990: 254).

The significance of these technologies lies not in their oppressive qualities but in their enabling ones, and these 'therapies of freedom' (Rose, 1990: 237) have been deployed throughout the social realm (Rose and Miller, 1992: 195).

However, the meaning of these technologies of the self, as elaborated by Rose and others, has attracted some criticism. One such problematic area is with the framing of these techniques as 'therapies of freedom' (see above Rose, 1990: 257-8). Garland,

(1997: 196-7) whilst seeing the critical importance of an analysis that suggests the connection between autonomy and control, points to what he perceives as a confused running together of two distinct ideas. Therapies of freedom fuses two concepts, one of agency and the other of freedom. Garland perceives the first as a 'universal attribute' of the capacity to act based on calculated decision making. Freedom he defines as a capacity concerning choice of action that is relative in terms of external constraint. Thus the encouragement of agency or decision making only opens up a new set of 'constrained possibilities' (1997: 197) that depending on the context may have the effect of further emancipation or contrarily may not.

These then are the theories that will be utilised to enhance the discussion of social control as applied to the analysis of drug policy. What remains to be done, as stated above, is to consolidate the examination of social control in terms of the analytical approaches to the study of the location of policy making discussed above.

Towards a Local Criminology

Recently within criminology there have been a number of attempts to discuss ideas relating to the local context. Analysis sometimes contrasts the local 'realities' with that of rather more abstract notions of globalisation or European 'marketisation'. Dick Hobbs (1998), for instance and Hobbs with Colin Dunningham (Hobbs and Dunningham, 1998) questions the concept of transnational organised crime through an ethnographic study of local criminal networks and the places they are located. They remain sceptical of descriptions of organised crime that enforce a conceptual polarity between the urban street gang and the globalised transnational cartel (Hobbs, 1998: 418). Whilst international chains may stretch across the globe this should not be taken to imply merely that the global acts and that the local reacts nor that any form of transnational homogeneity can override local differences (1998: 419). For the authors,

Organised crime is not experienced globally or transnationally, for these are abstract fields devoid of relations. Organised crime is essentially a tangible process of activity that is manifested in the context of locality (Hobbs and Dunningham, 1998: 300).

Indeed if we conceive the drugs trade as a homogenous international phenomenon we overlook the discrete contexts within which the various drugs are produced, refined, distributed to the markets, trafficked, re-distributed, sold, bought, consumed and all the variations of control that are deployed. For every transnational arrangement it is possible to say that there are many more local points and networks of experience be they in a Burmese jungle (McCoy, 1999) or a Kentucky farmstead (Weisheit, 1993).

Linked to notions of the global/local discourse is a similar theme that contrasts a localised context to that of a 'market Europe' (Ruggerio et al., 1998). This transnational model, the European Union, is characterised as primarily concerned with deregulated economics, attaining increased international growth and greater facilitation of cross border surveillance and policing (1998: 4). Interestingly for this dissertation, one vignette discussed by Ruggerio analyses the localised efforts of networks of drug agencies and users to develop alternative policies based in their communities. This comparative and alternative European criminology is not limited to localised study but it does demonstrate the diversity within European criminology. Notably the 'glocal' analysis of Hobbs and Dunningham is included in Ruggerio et al. as is the study of 'crime talk' and anxiety beyond the city in the town of Macclesfield by Girling et al. (1998). In the book that followed, *Crime and Social Change in Middle England* (Sparks et al., 2000) the importance of the local context is central. One of the leading suppositions of the authors is that much of the 'talk of crime' has a local setting that will include a perspective of place, of where people live, work, and socialise and a person's place within it (2000: 9). Broader forms of social change, such as fear and anxiety of crime, can be discovered through the lived crime discourses found through such work. Indeed as the authors point out,

The consequences of modernity for the security, identity and subjectivity of people anywhere can only be disclosed, grasped and rendered intelligible *somewhere* (Sparks et al., 2000: 10, emphasis in original).

This sense of local difference, 'somewhere', is evidenced elsewhere in a sociological study of change and place in 'A Tale of Two Cities' (Taylor et al., 1996). As part of a detailed comparison of two northern English cities, Manchester and Sheffield, in the post-Fordist age, it was argued that not only were the cities' crime rates different

(1996: 24-26) but that public concern about crime was located and experienced differently. In Sheffield's case the problem of crime was associated with the city centre, known as the 'Hole in the Road' (1996: 70) and was connected with deeper concerns of the crisis of the city centre (1996: 19). Manchester's crime problems were more heavily connected with outer lying estates, especially the almost mythically sensationalised 'Moss Side', and crimes of violence and gun culture reflected in the sobriquet of 'Gunchester' (1996: 84).

Whilst these works remain informed by, and agree broadly with, many of Simon and Feeley's (1995) descriptions of changing contemporary criminal justice and penal patterns these local studies are keen to point to the 'insensitivity to place' (Sparks et al., 2000: 163) that the grand mapping of social change produces. Such local studies, for example, often reveal a less than hegemonic culture of popular punitive responses to crime often assumed by broader analysis. It is not just that contrasting local cultures of interpretation, and even national political differences, remain unconstituted but that there is the:

tendency to *presume* that certain reconfigurations of criminal justice have global prevalence under late modern conditions, rather than to investigate how these mutations are received, resisted or altered in specific institutional and political settings, with all the *unevenness* that such enquiry is likely to reveal (Sparks et al., 2000: 163, emphasis in original).

Within the literature specific to drug enforcement and treatment policies there has been little in the way of conscious theoretical analysis of the local context in the way just described. Studies of police enforcement of laws against drugs have been numerous over the years. The structure of enforcement has been commonly perceived as operating on three different levels (see for example Dorn and Murji, 1992). First there is high-level drug enforcement which is aimed at the substantial manufacturers and importers. Middle-level policing is directed against what are called wholesale distributors who distribute drugs once they have been imported into an area. Then there is low-level drug enforcement (LLDE) that attempts to police both the 'street' dealers and the 'consumers' and by doing so breaking the chain in the trade. These units, to the more cynically inclined, may also have a more institutional function. Michael Connelly, a former police reporter for the Los Angeles Times described similar low-level units in the US as:

A numbers squad, created to make as many arrests as possible in order to help justify requests for more manpower, equipment and, most of all, overtime in the following year's budget. It did not matter that the DA's [District Attorney] office handed out probation deals on most of the cases and kicked the rest. What mattered were those arrest statistics (Connelly, 1996: 10).

As with this present doctoral research, low level enforcement studies are centred on a local area, a city, or area within it. Breaking the chain in the retailing of drugs usually means that police efforts will target either the low-level drug retailer (disruptive policing) or the drug purchaser (inconvenience policing) (Dorn and Murji, 1992: 162). As such, the concerns of these types of studies are primarily with police initiatives and action. The major emphasis is often on specific projects run by the police force in the area researched over a period of months. There is however, often an inclusion of the broader relationships between police authorities and other local agencies working in the area. These agencies are typically the local councils and what might be called the community drug agencies. This more 'social' approach, as Dorn and Murji call it, has been summarised as:

More specifically, local authorities, private sector firms, voluntary agencies and the police attempt to work together to tackle local social and economic problems, to reduce unemployment, to improve housing and amenities, to brighten streets and enhance lighting and to induce more community beat policing (Dorn and Murji, 1992: 166).

Mike Collison (1995) in his work 'Police, drugs and community' presents an in-depth case study of a force-level drug squad. In it he presents the findings of his rich ethnographic data on the workings of a local drug squad and how the 'job is actually accomplished' (1995: 14). He details the rather less than exciting daily life of the officers. The axis of detective work, intelligence gathering, is discussed with reference to the handling of informers and the monitoring of local players and suspects. Monitoring the drug scene for indications of change and perceptions of the market are mixed with descriptions of recruitment and self-presentations of the nature of the drug squad. Informal work routines and trading transactions provide a detailed description of the way that drug markets are managed rather in the form of a game. What comes across from this work is the way that a drug squad and even individual officers have on a working level great discretion over how they spend their time and what information they gather and what they do with it.

As a small caveat it might be kept in mind that the LLDE studies referred to above often post-date much of the time period studied in Edinburgh. In later studies there is then usually some discussion of the 'partnership approach' (Lee, 1996) and the inter-agency relationships that exist in the given area at the time. The analysis of this partnership is, as would be expected, focused on how other agencies assist the police in enforcement. This is achieved either indirectly through intermediate intervention in say local unemployment rates, or in the more direct fashion, found by Lee, of shutting down a hotel that was being used by dealers (Lee, 1996: 43).

Pearson (1992) has characterised LLDE as harm reduction. He discusses how LLDE 'contains' overall numbers and encourages other users into 'early retirement'. He draws attention to the often overlooked 'subtle compulsion' that is frequently present in drug service referral. Minimal criminalisation through offender diversion and reducing drug related crime and levels of community impact, form the other traits of LLDE as harm reduction.

By contrast, Fraser and George (1992), in their study of the policing of the heroin scene in Worthing noted that the disruption of a stable social network of drug use led, among other things; to an increase of 'bad deals', rip-offs, and presumably violence, together with more chaotic drug use. This increased chaotic drug use that did not necessarily involve heroin use, involved taking cocktails of drugs that were available, resulting in a marked increase in deaths by overdosing (Fraser and George, 1992: 165-166). Thus it may be seen that dispersing an already established drugs market, an inherent aim in LLDE, may contribute to more harm than it reduces, as Fraser and George concluded:

The tentative conclusion is that police action aimed at disrupting the distribution and social network of drug use has had a negative impact on the harmfulness of drug use (Fraser and George, 1992: 166).

It must also be remembered that these changes are relatively recent, bear little resemblance to tactics in evidence at the height of intravenous use and were likely the

product of concerns over HIV in the late 1980s. The previous 'harm maximisation' policing is obscured due to a missing socio-historical context.

Studies of agency response to drug use, other than law enforcement, predominantly occur outside criminological texts. Occasionally, works attempt an overlapping analysis, such as 'Policing and Prescribing' (Whynes and Bean, 1991) but are presented as a segmented overview rather than an integral unified analysis. Parker et al.'s (1988) Wirral study included some mention of the official response and 'civil war' between the lobbies but was focused more on use than control.

Much of the socio-medical literature has likewise been concerned with the study of drug users in a community setting, the amount and type of drug use, together with the use made of services available. Bucknall and Robertson's (1986) study of intravenous drug users in Edinburgh gave the following remit that seems to typify the principal aims of the research in this field:

1. To describe social characteristics and life histories of problem drug users in a community, working from a study population in a general practice with particular experience of drug users.
2. To examine the use made of services and support currently available in the Lothian Region for these drug users and attempt to correlate favourable outcomes (Robertson and Bucknall, 1986: 6).

Thus whilst there is both a developing literature of 'the local' in criminology and many studies of enforcement and treatment of drug use there is nothing that seemingly combines a conscious analysis of a wider gamut of agencies involved in drug control and the significance of their locally-based actions. Similarly the next section analyses the extent to which ideas of self-responsibilisation have been utilised in criminological study and more specifically within drug control.

Technologies, Crime and Responsibility

There have been few studies within criminology that have examined the role of these technologies of the self within social control more generally. Garland picks up on some of the general themes of this literature in his article 'The Limits of the Sovereign State' (Garland, 1996). In it he describes the way in which certain crimes have

become thought of as part of everyday (precautions) of life. Related to this is the realisation of the limited effectiveness of the state in curbing crime rates. Thus new strategies evolve in the shape of responsabilization (1996: 452). This encourages the growth of the non-state and individual agency in a shift of responsibility for crime prevention. Crawford shares this view in his attempt to show:

that appeals to prevention embody 'responsibilisation strategies', through which the state has attempted to redefine the legitimate expectations of the public in relation to crime control, as well as the criteria on which state performance should be judged (Crawford, 1998: 247).

Garland in a later article (1997) extends this examination of the use of technologies of the self/self-responsibilization to the penal realm and shows how it is used to assess responsible prisoners who respond to training and are deemed ready for release. Stanko (1997), in a discussion of crime prevention and women's risk of violence, argues that these techniques as adapted to crime prevention overlook the everyday inherent strategies of management adopted by women in relation to male violence. Stanko sees this type of technology of crime prevention as a form of performative femininity, the failure of which results in a further burden of risk resulting in a 'sullied self' (Stanko, 1997: 488). However, it seems that a certain measure of ambivalence in the language and meaning of responsabilisation exists. It would appear that Garland's earlier work, and that of Crawford, refers to a top-down devolution of duty and accountability for social problems to a lower level, as seems apparent when Garland states that:

The idea of a responsabilization strategy implies that the state is taking on an ambitious new role, not merely 'passing the buck', 'getting off the hook' or 'taking a back seat'. It is experimenting with ways of acting at a distance, of activating the governmental powers of 'private' agencies, of co-ordinating interests and setting up chains of co-operative action, all of which present many more difficulties than the traditional method of issuing commands to state agencies and their functionaries (Garland, 1996: 454).

This devolved version of responsabilisation is constructed at the macro level of analysis and seemingly is not the same as the distinct process undertaken at the necessarily micro personal level that Garland refers to in his later article. This later practice that Garland calls self-regulation, whereby the individual attempts a transformation through guidance and self-monitoring, shares a common quality and can be equated with the earlier described practices or technologies of the self. It is this

version, described by Foucault and Rose, that seems better able to carry the term of self-responsibilisation and will thus be followed in this work.

George Pavlich (1996) explores the use of these techniques within 'alternative justice' community mediation programmes. These programmes, generally, were conceived to provide disputants with a recourse to mediation outwith the formal setting of the criminal or, as in this case, civil court system. The first major tenet of Pavlich's argument is that traditional discourses surrounding the uses of community mediation are misconceived:

They have, in short, narrowed the debate on community mediation to an exploration of the extent to which it expands and/or intensifies state control. In the process, sustained analysis of community mediation as possibly harbouring elements that are not embedded in state control, or functional for the latter, are not placed on critical agendas (Pavlich, 1996: 713).

Pavlich, by contrast, seeks to analyse the application of community mediation as a deployment of techniques, primarily, of the self. Through case study review the significance of the dynamic role of the confessional relationship between disputants and mediator is highlighted. In this particular case resolution failed signalling that attempted transformation was resisted pointing out the open-ended nature of this mode of control.

There is little in the way of specific or even tangential mention of strategies of self-responsibilisation within the literature on drugs before the advent of HIV. After the discovery of HIV, this literature tended to focus on HIV prevention in the drug-using context. McRae's (1989) monograph not only describes the services initiated in Edinburgh but includes a brief mention of a connection between HIV prevention, drug worker/user relationships and encouraging behavioural change (McRae, 1989: 22). Discussion surrounding choice, lifestyle and behavioural change in relation to drug use has been increasingly evident in the socio-medical literature (Ritson, 1986, Stimson, 1990). For these commentators it represents a major change in the type and style of treatment. More and more attention is given to the importance of, and the way that, the drug user can be co-opted into these self-help techniques (Ritson, 1986). Deployment of these technologies received added impetus from anxiety surrounding HIV infection and the perceived inadequacy of existing policies:

Preventive education, penal deterrence and treatment to help people become abstinent, all have an extremely dismal impact on the prevalence of drug problems (Stimson, 1990: 126).

In language reminiscent of Foucault and Rose, Stimson echoes the recognition of the difference of these policies and the essence of self-responsibilisation:

The changes suppose a changed relationship between the professional worker and client...This involves enticing injectors through 'user friendly services' and 'empowering' injectors to change their behaviour by providing them with the information and promoting motivation to change, and the means to make those changes (Stimson, 1990: 129).

In conclusion Stimson signals both the distinct nature of these new forms of treatment combined with an appreciation of their origins:

We lack the benefit of historical distancing and hindsight which facilitates our attempts to analyse previous periods in drug policy. As presented here, these new ideas appear as a distinct break with earlier ones, but as with many conceptual and practical changes, the possibilities are inherent in earlier ideas and work. It is perhaps a matter of emphasis and direction, rather than abrupt rupture with the recent past (Stimson, 1990: 129).

Through the analysis of the different phases of drug policy, an evolution of drug control can be constructed which will go some way to explaining the connections between these 'new ideas' and those that preceded them. There does seem at least to be a definite recognition of the emergence of a new type of technique even if it remains rather undeveloped.

Harm reduction policies have also featured in the drugs literature of the Netherlands some of which will be discussed in later arguments. Within this context attention has also become focused on the more broadly employed concept of 'normalization'. This de-escalation of the social (drugs) conflict, by de-mystifying use and user (Leuw and Marshall, 1994: x), is not directed at the point of individual subjectivity, but instead seeks to affect the realm of the public/social consciousness. Normalisation could be characterised as more like an example of Rose's mentalities or 'regimes of truth' attempting to reverse the current social construction of the drug problem, in which it is seen as being synonymous with decriminalization (1994: x). As we shall see technologies of the self deployed in relation to drug use may implicitly question the approach of criminalisation.

What these discourses on harm-reduction policies have seemingly omitted is any deep analysis of how these measures actually control drug users. Harm reduction discourse is devoid of any broader theoretical framework that explores the evolution of these policies independent of the phenomenon itself. Harm reduction discourse does not provide, to any great extent, an analysis of the deeper meaning of the policies and their links to broader questions of social control. It is almost as though writers of harm reduction have assumed a certain ‘value free’ transformation, that overlooks or does not explore the relationship between behavioural transformation and discourses of social control. In saying this there have been limited instances where this connection is partially recognised and talk of control (Hartgers et al., 1992: 857). However harm reduction policies remain situated as the antithesis of *social control* measures of criminalization. This offers a simplistic dichotomous framework that cannot enable the exploration of the subtleties of social control mechanisms that have existed and been pursued in other fields. Up to now this analysis has been utilised in the analysis of ‘sexuality’ by Foucault and, arguably, the general rise of Rose’s modern psychotherapies that became enmeshed within the management of the individual from the work place, to the hospital. By studying how these technologies of the self were applied to the individual’s subjectivity, an evolution of a different type of drugs control policy can be described and analysed. This combined with an analysis of more traditional techniques of control enables a more complete examination of control and the changes in control that attach to the individual and makes them subjects to power.

The chapters that follow will develop these two themes of location and changing control. They will attempt to unravel the evolution of drug policy both in relation to a deeper analysis of social control and with reference to the location of power and the study of a local policy formation. This will provide a fuller analysis of how intravenous drugs were controlled in Edinburgh in the times leading up to and throughout their most prevalent use. It will offer an understanding of the way that knowledges/technologies are both formed and put to use, and will help develop a more fully grounded analysis of how the field of drug control is problematized and operates.

CHAPTER 2

RENUNCIATION AND PROHIBITION: Intravenous Drugs Policies in 1970's Edinburgh

This chapter marks the start of the empirical examination of the way intravenous drug use was controlled in Edinburgh and how practices changed over time. The evidence presented in this chapter is concerned with seeking to establish the nature of drug policies in Edinburgh in the period from the late 1960s to the late 1970s, how they evolved and the manner in which they changed. The empirical research provides evidence to support and develop the two main theoretical assertions of this dissertation. First the evidence in this chapter provides particular support to the argument that the policy formation originated from within Edinburgh itself. Secondly examples of the emergence of distinct changes in policy, whilst not examples of fully formed techniques of self-responsibilisation, are identified as distinct practices of a more pragmatic everyday reality.

This chapter will begin with a brief note on the methodology and sources employed in this dissertation. This will be followed by an account of the Edinburgh intravenous drug scene in the late 1960s through to the 1970s. Next the detailed discussion of treatment, policing and resistance by drug users to these policies will provide the point of contrast for policies that followed later. Within this analysis of early intravenous drug policy there are two additional points that should be noted. First, even at this early stage there are genuine instances where drug policy was initiated and determined at the city level. Secondly, that from the outset the reality of drug policy consisted of a range of - often divergent - responses reflecting the contested nature of drug control.

Methodology

The focus of this dissertation is the study of the ways injecting drug use has been controlled in Edinburgh and the manner in which policy change has occurred over time. Research methods used should be the ones that help to answer the research questions identified by the dissertation. The units of analysis (Jupp, 2000:19) for this

study are the individuals and institutions responsible for drug control policies, the contextual data of the drug scene in Edinburgh, and the events and changes in policy that evolved over time. The most appropriate research methods are the ones that can best deliver data on these units. In the light of such requirements two approaches were taken. First there was an extensive search for documentary evidence relating to drug policy in Edinburgh. Secondly, a series of interviews of key policy informants was arranged. From the initial stages of the study it was realised that the 'grey literature' (for example minutes of health, regional and local council committee meetings) would not on their own have provided the necessary sources of material for this project. This is because, almost all of the recorded material relating to health and council committees starts from 1987. The central government reports such as those produced by the Advisory Council on Drug Misuse were available but this still leaves the majority of the important period in drug policy evolution in Edinburgh, studied here, uncovered. Committee materials prior to this are scarce. For example, a regional council report on drug abuse in 1983 is only 13 pages long and covers everything from solvent abuse, trafficking, and comparisons with England to education (Lothian Regional Council, 1983). The first 'detailed' study of policy and services provided in Edinburgh does not occur until 1986, approximately one year before the threat of HIV became recognised. The local newspaper cuttings, held by the central city lending library – and unobtainable from the newspapers themselves – date back only to 1985. Whilst interesting, the majority of news coverage, as found in a subsequent search of newspaper reports from 1980-1984, focus on seizures of drugs, predominantly cannabis, and not policy initiatives. Thus whilst the Secretariat to the Health Board (the administrative department of the council) file's were examined and their minutes relating to the meetings of the Joint Working Party on Addictions, Social Work, Planning and Resources and other related sub-committees noted, other methodological approaches were required.

The second research method used was that of interviews. Criminological research methods literature on theory and practice in general and on interviewing in particular has grown significantly in recent years (Jupp et al., 2000; King and Wincup, 2001; Brookman et al., 1999; Bachmann and Schutt, 2001). For the purposes of this

dissertation a summary of some of the major features of doing interviews will be combined with issues related to the research completed in Edinburgh.

Perhaps the first question asked of using such qualitative methods is when is it appropriate to use interviews for research. Denscombe provides the following recommendation:

In practice, the crucial choice as far as whether or not to use interviews is concerned is between, on the one hand, gathering more superficial information from a large number of people and, on the other hand, collecting more detailed information from a smaller number of people. The use of interviews normally means that the researcher has reached the decision that, for the purposes of the particular project in mind, the research would be better served by getting material which provides more of an in-depth insight into the topic, drawing on information provided by fewer informants (Denscombe, 1998: 111).

One of the distinct advantages of this qualitative approach is that it can fill in 'gaps in documentation' (Cockcroft, 1999) which as already noted existed in relation to this research. Having said this, the interview approach should not be seen in this dissertation as a method of last resort. The opposite is true, in that, gaining the detailed knowledge of what drug control policies in everyday practice and reality consisted of and how they changed, was precisely the information that interviews can supply. Establishing the motives, assumptions, experiences and techniques deployed in drug control might not have been as revealing if pursued through questionnaires, for example. Another reason for the requirement of detailed knowledge and a considerable advantage was the 'discovery of entirely new knowledge' (Cockcroft, 1999: 137). The research started with a broad enquiry into drug control in Edinburgh. Such a broad area of enquiry tends to be more typical in qualitative work and has been described by Jupp as a 'signpost' to the direction of inquiry (Jupp, 2000: 22). In this particular research this allowed the 'progressive focusing' and 'refinement of ideas...in line with what is discovered' as the interview fieldwork progressed (2000: 28). What this 'discovery of new knowledge' through the 'progressive focusing' unearthed was the possibility of linking the theoretical assertions, discussed in Chapter One, with the empirical evidence that started to be gained through what those involved in policy said. Through the 'selective adoption' (Bottoms, 2000: 39) of general social theories such as those of Foucault and of other associated concepts, it allowed the research 'to use GST [general social theory] concepts in a sparing and

critical fashion that hopefully really can illuminate the social phenomena being studied' (2000: 39). Through the reflection and insight granted by these interviews it became apparent that there was a resonance with certain Foucauldian concepts of local centres of power and techniques of the self and that this approach also appeared novel within the field related to drug control.

This brings us to another methodological question of the advisability of relying on information gathered from a small number of informants. One justification for aiming for such depth is that the data is based on privileged information (Denscombe, 1998: 111). The interviews in this research were based on the value of information obtained with key policy players in Edinburgh who alone could give privileged information. Whilst data on the context of say the Edinburgh drug scene can be obtained from a number of published sources the primary focus was always on drug policy and those who were on the spot and in a 'special position to know' (1998: 111). This validity of the quality of interviewees was demonstrated by the number of times this close knit community would mention one another, for example where some of the former heroin users interviewed could often name at least two of the three original members of the Drugs Squad. This cross-referencing not only confirmed the position of interviewees as 'in the know' but provided a useful method for snowballing the series of interviews.

There is a second point in regards to validity important to interviewing. This relates to how accurate people's memories are. Oral historians such as Thompson (1988) have addressed this question by viewing memory process as depending on perception that is fitted into categories for the future (1988: 110). Any discarding, if it does happen, does so at a very early stage so that tested inaccuracies show no difference between months or years later (1988: 112). In addition memory process not only depends upon comprehension but interest:

Accurate memory is thus much more likely when it meets a social interest or need (Thompson, 1988: 113).

Thus while losses are likely to have been made, they will have done so in the days or weeks that followed rather than the months or years. Secondly because these memories were at the centre of interviewees daily lives it can be said with some confidence that it was of interest and or need for them. Lastly it must be remembered as Thompson points out that even quantitative surveys suffer from changed or omitted questions, probing and recording errors (1988: 122-123).

Access is always a key to interview research and in the present research this issue proved in the most part relatively easy in no small part to the willingness of others to give up their valuable time. Some access was facilitated through previous interviews; some even through friends or their relatives who knew the research being undertaken. In the case of the police access was aided immeasurably by the fact that the researcher had previously studied alongside a senior-ranking officer. Interviews themselves always moved along a continuum between semi and unstructured. Whilst it was necessary to include certain questions the object was always to allow interviewees to speak their minds as the primary aim of these interviews was 'discovery rather than checking' (Denscombe, 2000, 113). The demeanour I took in the interview could perhaps best be described as 'someone who is neither firmly entrenched in the mainstream nor too far at any particular margin' (Miller and Glassner, 1997). The interviews were conducted throughout with permission and assurance of confidentiality, and were all taped and transcribed. In all thirty interviews lasting anywhere between forty-five minutes to two and a half hours, though mostly being between sixty and ninety minutes, long were undertaken generating over four hundred and fifty transcribed pages. Whilst certain text analysis software - such as HyperRESEARCH and QSR Nvivo - could have been used this would have proved difficult because sections retrieved under headings of 'drugs' or 'policy' would have been too general (see Bachmann and Schutt, 2001: 314) and unlikely to bring out the more subtle resonances used to match theory to practice. Instead notes were made in the margin of the transcripts in order to code important points (2001: 310).

Documents, published or unpublished, were used increasingly as the research progressed in period to establish internal validity. Nowhere else was this more true

than in relation to the comparative literature used to analyse other European cities experiences. This material proved important for two reasons. First it provided an aspect of what Jupp calls external validity or whether it is possible to argue that conclusions are relevant to other contexts (Jupp, 2000: 10). Secondly these materials provided for the further 'discovery' of new trans-local links in drug policy.

In the following section the Edinburgh intravenous drug scene will be set in relation to its size, social composition and how drugs were obtained in that group. The sections that appear after will describe and analyse how this comparatively small social phenomenon was controlled in the 1970s.

From Chemist Shops to Chinese Elephants: Obtaining Drugs in Edinburgh during the 1970s.

This section is designed to illustrate some of the practices drug users used to obtain illegal supplies of intravenous drugs in Edinburgh during the 1970s. Prior to the development of large scale importation of heroin from abroad, the type of drugs injected in Edinburgh relied to a large extent on what could be obtained as a result of various different forms of theft. The major source of supply came as a result of breaking into chemist shops, details of which are corroborated both below and later on in the section on policing. In the extract below an ex-drug user of the time illustrates one procedure of a chemist shop break-in:

We just used to take it from the shop like two o'clock in the morning. It was so simple. A lot of chemists round here didn't even have bars on the windows right...On the wall there would be a cabinet with DDA (Dangerous Drugs Act) on it, telling you where it was. There would be riches of stuff dating back as far as 1930. You'd see the bottle with 1930 on [or] 1940 during the war. You'd get ounces of the stuff. You'd get it in all forms, you'd get it in ampoule form, you'd get it in powder form, and you'd get it in pill form. You'd get every type, like you'd get diamorphine hydrochloride, diamorphine sulphate...You knew that [if] you were going into a chemists you were coming out with bags of stuff and all the derivatives as well.

Further evidence of the variety of drugs taken from chemist shops is contained in the extract below, from an ex-drug user, together with an albeit limited ethnographic detail surrounding use of medical information to research and experiment in drug use:

We used to take it [the drugs] and then go back to an arranged house and sort it from there. I remember we would go right that's worthless, that's got a synthetic morphine base we'll keep that. Oddly enough, for years and years, the most expensive drug now on the market, we used to throw away because we didnae know what it was.....I can remember the first time the 'Guinea Pig' said "Every time I break into a chemist's I always see these pink tablets, but naebody's ever tried them, so let's get the MIMS [a medical reference book] book out." He'd be like that "Dipipanone, ah it's got a heroin base, I'll try it." [I said] "Oh it's up to you if you want to try it." So he's crushed up two or three and he's being the guinea pig and "Pharr man have I been throwing them away for the last years?"

A second source of injectable drugs came from what may be called 'conning the doctor'. Drugs obtained in this way were synthetic analgesics or barbiturates, such as Palfium and Tuinal. These drugs could of course feature in any haul from a chemist's shop break-in. In order to 'con the doctor' drug users would complain of some fitting illness and hope to get a supply of barbiturates, as an ex-drug user relates:

In the early days it was easy to con a doctor to get the derivatives, if you like. The times I used to go into a doctor like and say "Ahm suffering from neuralgia I need Palfium."[or] "Ah cannae sleep, my auntie gave me Tuinal".....He'd look it up and say "I'll start you off on fifty a week right", stupid doctor.

This con game relied on some knowledge of drugs and what they were conventionally used for, together with an understanding of who the right kind of doctor was:

There were certain doctors like, 'ah he's quite a sympathetic doctor', but he thought you had neuralgia. He didnae think you were abusing it, there wasn't any danger of him going like that....He would just think, 'ah well neuralgia is a painful thing here you are'.

Later, as doctors became increasingly suspicious, stealing prescription pads became an alternative route to secure these drugs. At first drug users would steal a whole book of prescription forms and then forge prescriptions. This practice later became more cautious, with drug users just opening up the unnumbered pad and taking two or three pages out to avoid detection. This method still necessitated the collection of the drugs from a chemist and was far from foolproof as the oral extract contained below from an ex-user, illustrates:

They [the chemists] started getting told by the police to watch out for forged prescriptions like that. So if a chemist said twenty minutes....and you'd come back in twenty minutes and on the other side of the road you'd see if any [unmarked] police cars were there like that. Surely nine times out of ten a police car would draw up. You go like that, 'well ah'm no going back for that one'.

Some drug users received methadone and other drugs as part of their psychiatric treatment. The Andrew Duncan Clinic, at the Royal Edinburgh Hospital in Morningside, started to prescribe methadone to outpatients in the early seventies analysed in the next section of this chapter.

Another source from which pharmaceutical drugs could be stolen from was life boats as one Drugs Squad officer at the time remembers:

The docks down at Leith and Granton were far busier then they are now. The ships that came in always have the life boats on board. Inside the life boat there is an emergency drugs cabinet which always contained morphine and these were extremely popular....The actual amount they got away from any life boat was probably about six ampoules and six syringes, but it was worth their while and these were done regularly.

During this period needle and syringe availability seems not to have assumed the importance that it later would. Fresh supplies of needles/syringes were available from chemist shops using a small amount of subterfuge: As one injector at the time recalls:

It was quite easy to go into a chemist shop with a diabetic card, quite easy. You'd always get someone willing to give you their card...like that 'no problem Sir'. Their wasnae that many people using. There was only a select little group of people that used to use smack. You could get as many as you want.

The relatively small intravenous drugs scene at this time, seemingly aroused little suspicion among chemists that they should guard their supply of needles cautiously.

Numbers and social background

This section is designed to provide information on the perceived levels of heroin use in Edinburgh and further afield. Ward (1971) notes that the number of persons caught in possession of narcotics in Edinburgh in 1970 numbered 29 (Ward, 1971: 377). This relatively small number represented an increase from the previous year during which only 15 arrests for possession were made¹.

Official Home Office notifications, made by doctors, are of little help here for a few reasons. During all the periods discussed in this dissertation, all medical practitioners

were required to disclose to the Chief Medical Officer at the Home Office all persons they knew to be addicted to drugs specified in the 1971 Misuse of Drugs Act. The information is then put on an index that only medical practitioners can access. This index offers a reflection of medical services demanded by drug takers. There are numerous shortcomings in using these statistics as an accurate reflection of intravenous drug use. First they would cover a wide range of drug user, including say a 70-year-old woman who was getting tuinal barbiturates on prescription and not part of the illegal drugs scene. Secondly they may be receiving certain drugs but they may not necessarily be injecting them. These statistics will not reveal those drug users that avoided detection or medical practice altogether. Lastly, as Haw and Liddell (1988) noted, medical practitioner discretion had the potential to skew the statistics for the following reasons:

As well as some suspicion about the confidentiality of the index which deters some doctors from notifying, others only notify when controlled drugs are prescribed (Haw and Liddell, 1988: 9).

However, from the interview data gathered there seems to be agreement between psychiatrists, Drugs Squad officers and drug users during the period that the number was stable in the region of 40-50. The intravenous drug-using scene was small enough that most people involved, users and Drugs Squad officers, knew who each other were, at least by sight, as a drug user at the time remembers:

You could go into a pub in Leith, if you came from Dalry [the other end of town] area, and if that person in Leith was into the smack scene you'd probably know him. It was that close knit at the time. The D.S. [Drugs Squad] which consisted of one [black] Austin Cambridge car that everybody knew and the three D.S., it was just a Drugs Squad of three. Everybody knew who they were, everybody knew their car and that's how small it was and they knew who the drug users were. It wasn't a case of now like I wonder if they're into that.

Similarly, the Drugs Squad were aware of some of the abodes and meeting places of many of the drug users of the time. They knew, for example, some drug users would use a well-known city centre pub as a meeting place where "They used to sit diagonally opposite the toilets near the old police box."

¹ It must be remembered that this is not an attempt to describe the whole Edinburgh drug scene.

The Scottish Home and Health Department's (SHHD 1972) report 'Misuse of Drugs in Scotland' chaired by J.A. Ward, included data from statistical sources (police and Home Office) and oral evidence from social/health workers pharmacists and the police. The rise of convictions after 1968 involving opioids (SHHD, 1972: 6) was a source of concern, combined with the discovery, from oral testimony, of groups of hard drug users that did not attend treatment centres but depended on black market drugs procured illegitimately as previously detailed. Amongst the Ward Committee's other findings included an identified number (86) of users attending London treatment centres who gave their birthplace as Scotland (1972: 9). Thus Scotland's drug problem could in some ways be seen as not being confined to her own borders but was subject to export. Interestingly at this time the lack of support that social work or probation could offer to the motivation of drug users in the community was noted (1972: 15). This was coupled, curiously for the time, with a recognition of the importance of the development of voluntary agencies as being less likely to be identified with the 'establishment' and more able to establish a rapport with difficult-to-contact groups (1972: 16). However, it was noted at the time that there were very few resources for primary care of drug dependent people in Scotland.

Further afield in Glasgow Fish et al.'s (1974) self-report study of pupils, students, casualty patients and young offenders found 58 heroin users out of 2809 people sampled, of whom just 15 were regular users. Heroin at this point was seen as a small problem. Plant's study in Cheltenham (1975) of a predominantly mixed (socio-economically) sample (n=200) of cannabis users revealed similarly low rates of 12% life time use and 1.5% regular heroin usage. Research conducted by de Alarcon and Rathod's (1968) in Crawley revealed 12 confirmed daily takers amongst 50 users from probation, police and casualty records (1968: 551). Whilst the social background of users was representative of the town more generally (1968: 552) the supply was sourced in London possibly explaining these higher rates. Kosviner et al.'s (1968) study in an undisclosed provincial town revealed 37 heroin users, 17 of whom took the drug daily. Supply again was from London through registered users. Use reflected the characteristics of the town and was predominantly spread through the lower socio-economic levels. Although these rates were low, compared to those to come in the

1980s, these studies did portray much higher rates in English towns than had been previously been recognised. This pointed to the suspicion raised by some (1968: 1192) that existing services were not capable of picking up this hidden number. The local variations depicted in the smaller towns seem to have been representative of the local populous. Additionally the commentary points to early worries surrounding state provision and how local responses were both lacking and desired.

Socio-economic Background

This section on social background reveals a certain duality in the drugs scene. The first extract from one of the few doctors in Edinburgh seeing drug using patients in the mid-seventies described her clientele as generally having the following characteristics:

I would say working class backgrounds. The ones we saw, late teens early twenties, the males would give as their occupation or previous occupation labouring jobs or house painters that was a popular one; or that was a common habitus rather than an occupation, so a lot of them were on the dole.

Bewley and Ben-Arie's (1968) study in Tooting Bec, London, mirrors this perception of working class heroin use. However whilst lower class heroin use was always mentioned there was additionally evidence of some middle class use. The extract below, from one Drugs Squad officer, seems to some extent contradictory on how much middle class use there was:

Mainly the serious opiate addictive type users were mainly from the lower socio-economic groups...You occasionally came across people from a very good background with too much cash. That was fairly regular, we've got a fairly healthy hit list of some good families....[They were] a fairly small percentage overall you know certainly in the opiate scene.

Wealthier households would be staked out on occasion but drug users of a higher class would tend to be caught either when a house was raided in another area of Edinburgh, or through a certain naivety as one officer recounts:

They would fall into our hands through stupidity. I remember one son of a government minister [at the time] who got stuff sent to himself through the post. A local postie delivering it reported it. The package had burst.

This, and the extract from one user below, points to a less visible and more exclusive middle class heroin scene:

Basically like well I suppose it's the schemes they were highlighted, the deprivation. But I know plenty, plenty, people like middle class smack scene and you couldnae get near them like. I'm talking ***** Lord ***** son. That type they had their own wee exclusive smack group.

Whether or not there was a 'Morphine Jet Set' in Edinburgh there is evidence that there was middle class use and it was of a less visible kind and therefore less accessible to drug control agencies. This in turn suggests that the drug control system was geared and directed towards managing that part of the scene that was visible and more threatening. Middle class use existed but these users went to other areas of town to get their drugs, or got them posted home, and then protected their anonymity through exclusive access to their group.

During the late 1960s through to the late 1970s the intravenous drug scene in Edinburgh was characterised by a supply derived from theft of drugs themselves amongst a small group of users but of varying social class, visibility and control. The next sections of this chapter will chart the response of agencies involved in drug use policy.

Psychiatry: Renunciation, Resistance and Local Autonomy

Psychiatry's role in drug issues became more central as a result of changes made in the mid 1960s. The Second Brain Committee (1965) recommended the centralisation of the prescription of Class A drugs (incorporated into the 1967 Dangerous Drugs Act; see Wille, 1981; Bewley, 1968; Stimson et al., 1978). The resultant Drug Dependence Clinics (DDCs), set up in the late sixties, offered a centralised service within a region with nominated staff. The service offered varied, as did the facilities. Some formed a specific unit in a hospital, whilst others as in Edinburgh's case, were integrated with other psychiatric in- and outpatients. The psychiatrist principally involved with drug users, from the late sixties to late seventies, had responsibility for

two of the four psychiatric wards at the Andrew Duncan Clinic. He describes how he became involved with treating drug users as follows:

One of my wards was the acute disturbed male ward, so that was the beginning of my likely involvement with young men who were being quite difficult. One of the great changes was when it was insisted that certain people had to be nominated as drug experts allowed to prescribe. That was a government policy that named people only were allowed to write prescriptions for the dangerous drugs. I was on the spot to do that and that's what kept me going in the drugs scene.....I was in charge of this acute general adult male ward and therefore when there was a big hoo-ha about someone coming up saying they wanted to get off their drugs I would find myself having them in my ward.

The time committed to dealing with drug users amounted roughly to half a day a week for him, dealing with around ten drug users at any one time. Thus the policy of the Psychiatry Department was in the hands of one isolated individual as the disclosure below reveals:

I don't know who the 'we' were. I'll say me, because I think I discussed it with people outside Edinburgh but I don't think there were others very interested. They were glad I was dealing with it at the time.

This 'isolation' was also evident in relation to the lack of contact he had within the hierarchy of the Hospital:

Q. Who were you responsible to, did you have to put out memos saying what you were doing to somebody 'upstairs'?

A. Not a word.

Q. You were just left to get on with it...

A. And you did the best you could with what you knew. I don't think anyone actually wanted to know too much, I mean in the way of 'go on, you're doing a great job'. There was never a hospital policy meeting about it until very near the end of my stint.

Even at this early stage then the responsibility for treatment policy was rooted in the ground level. Further, as we shall see in the sections that follow, not only was the responsibility a matter of local context but that the actual changing initiatives and content of policy were determined within, as Foucault (1979a: 98) terms it, the local centre of power relations.

Treatment and Problems of Control: The Lumped-in Drug User

The initial treatment, at the very start of the 1970s, given in the Psychiatric Department was one of reduction using substitute drugs on an inpatient basis. The consultant describes this policy and its failure as follows:

The usual story they came along with was that they wanted off their drugs. "Yeah sure we'll take you off your drugs. What we'll do is we'll get to know you a bit and then we'll take you into the ward and we'll help you come off the drugs. We'll gradually reduce the dose and we'll give you other drugs instead". It seemed a pretty simple, very reasonable proposal. Of course the same said lad said, "Yes that's great doctor yes fine". But of course it was doomed to failure. You took them into the ward and they usually left after 24 hours having had a great blow up with the nursing staff and would never darken your doorstep again.

This relative lack of success in retaining patients and continuing treatment is confirmed by the following extract from a then drug user admitted to the ward:

You were admitted for two or three weeks, not that I know of anybody on the drug scene that stayed anymore than two days because of the policy and the way they worked there. That is basically like they slung drug addicts in with the psychotics and alcoholics and schizophrenics, all in the same therapy groups. "Aw aye" [they said] "I want youse all to get up and dance to this music" and put a record on. Naebody lasted more than a day. "It's okay I'll withdraw outside", it's as simple as that they just never had a policy in those days at the [Andrew] Duncan [Clinic].

Vestiges of the perception of drug users as suffering from some mental health problem associated with personality can still be traced around this time. Bennie et al. (1972), who were at the time senior registrar and consultant psychiatrists at one of the psychiatric hospitals (Leverndale) serving Glasgow, had the following to say on the personal characteristics of those drug users they treated:

We have found them to be abnormal personalities. Traits of sensitivity, impulsivity and depression are in evidence and antedated drug experience. They are poorly integrated personalities who are unable to direct their rebelliousness and non-conforming habits. Neurotic and some near psychotic personality traits are present. Ego strength is low. The patients tend to see life in a gloomy and hopeless fashion. They feel overwhelmed by different impulses.... These patients come from families where the mother has been over protective, preventing development of security and independence. The father is usually either an over-indulgent inappropriately trusting passive person, lacking in masculinity.....Some patients are able to talk about their sexual problems, usually regarding homosexuality (Bennie et al., 1972: 104).

It is clear then that even in the seventies there were some who perceived the drug user as having abnormal mental health. The employment of personality testing was also in evidence in Blumberg's (1976) research in London during this decade. These

psychiatric regimes of truth, ways of knowing, were not fully put to use in the context of Edinburgh drug injectors. Whilst they were included in group activities with other psychiatric patients this was only for a short fixed term period of detoxification. This hybrid technique, as noted later, reflected the ambiguous psychiatric opinion of this disorder. Infractions of the treatment process, such as the continued use of any illegal drugs or anti-social behaviour were treated in an absolute prohibitory manner. This psychiatric regime frequently led to a breakdown in treatment between consultant and drug user often resulting in the latter leaving by their own decision or at the behest of the medical staff. Traditional psychiatric ways of knowing functioned differently in the local context and did not stand still over time. As the following section shows, as the 1970s progressed, policy became less informed by traditional psychiatry than a hybrid practical notion of service provision and containment. Whilst ambitious hopes may have characterised the first phase of drug treatment, rather than enabling and self-responsibilising ones (Rose, 1990: 237), this failure of treatment represented the likelihood of continued illicit drug use.

Maintenance, Disillusionment and Resistance: Blood, Sweat and Tears

The first change in policy and treatment offered was characterised by a move towards maintenance away from reduction in 1972/3. An impetus for this change came about after a visit to the United States:

I'd had a chance of a quick visit to America, to Philadelphia, and I'd talked to people there about the drug scene. I heard for the first time about a policy of oral methadone and went to see the clinics. Even there, at that time, the staff confessed that although they were giving people their dose of methadone on the spot they would keep it in their mouth and go outside and sell it to their friends. So we had to accept that it was a slightly dicey business. Anyway I came back and we tried giving them alternative drugs like other tranquillisers and all that would happen was they took the tranquillisers and went back to town to get the drugs [heroin]. That wasn't much use so then we tried oral methadone, we must have got through bottles of the stuff.

Psychiatric treatment changed significantly from one based on inpatient reduced dosage leading to abstinence, towards an outpatient methadone maintenance programme. This was done in an attempt to keep at least some of the drug users in treatment, as the tactic of detoxification had failed to do. Whilst the wish for a cure or end to drug taking was still present, the method of obtaining this abstinence was

evolving into something less indirect. By 1972/3 the emphasis was on influencing the type of drug and how it was taken rather than curtailing use altogether. Treatment was to draw closer street use when methadone started to be given in ampoule form for injecting. Later a room was added in the outpatients department where injection would take place upon receipt of dosage. The psychiatrist rationalised the move from tablet to ampoule methadone by saying:

You gave them tablets and then you discovered that they were melting them down, crushing them up and putting them into their veins so you might as well give them the right stuff.

The prescriptions, written on a pink form, were at this time handed in at *Boots The Chemist* in Shandwick Place. This practice was changed, with the hospital pharmacy replacing Boots as the place where prescribed dosages were obtained. This and the facilities for injecting, as the consultant describes below, were introduced for the following related reasons:

We reached a stage that they [the drug users] were being so difficult outside in using intravenous methadone to sell. You know the story was, "I've broken my ampoule", "a lorry ran over my ampoule"...I got the whole lot. It might have been true, but you began to realise it was highly unlikely. So my next game was to say, 'All right, I'm not going to go on doing this. What I will do, is to allow you to have a prescription here in the out-patients department and you can go into a room at the end of the corridor there.....we'll give you syringes, needles and do your own injection and that's it.'

However this attempt at a closer surveillance of the prescription and administration of the drugs had other unforeseen consequences as the consultant recounts:

Well that created havoc as you can imagine. These hearty lads, these very aggressive lads, would arrive up in amongst our middle class Morningside depressed ladies, absolute havoc. What they'd done, they would go in there having probably had a fight with one of their mates, out in amongst the middle aged Morningside depressed ladies, they'd then go into this end room and fight with themselves to get a vein. There'd be blood everywhere all over the room and a sort of smell of sweat and tears it was appalling.

The difficulty in managing this group of drug users within a psychiatric regime became increasingly apparent as the consultant relates:

Another very important point, it is so much against your whole ethos of psychiatry where you don't get taken for a ride by people, you hope. You really have to empathise with people. You really have to get into their feelings to do any good. You couldn't get near these chaps, when you did get into it they just threw it back into your face. It was very emotionally hard.

This psychiatric policy found itself trapped within a conundrum, partially, of its own making. In order to effect a cure the psychiatrist had to get inside the mind to empathise that proved impossible in the cases where the drug user wished to maintain his/her consumption of drugs. The ensuing impasse, as the consultant reflects below, led to an increasing sense of disillusionment:

I became more and more disillusioned, disheartened and alert to the fact that what I gave, however it was arranged, either they managed to sell some of it or they were using it plus anything they could get their hands on.

This growing disillusionment thus paralleled the movement from detoxification to maintenance, moving away from a faith and mentality in curing drug users towards a policy of containment:

I always tried to believe that in some of these cases my ultimate object was to cure them. The second objective was to keep them out of trouble and put them on a level basis....So in a way you felt you were doing a public duty. I don't know if it's a medical duty but it's a public duty anyway, in trying to contain the problem.

This disenchantment also reflected a feeling that psychiatric policy was not working with drug users because it was 'inappropriate'. The reluctance of colleagues to become involved implied that they were not so charitable as the psychiatric consultant reflected:

I think there were a few reasons for reluctance. The main one was clinical. The feeling that they were treating other more important cases and these lot just came in and mucked up the ward of their out-patient clinics.

The consultant at the time received little support for providing a service where the patients showed a lack of response to clinical treatment. The perceived lack of importance can be said to stem from a disbelief in the suitability of drug users receiving psychiatric treatment. Even the consultant expressed the opinion that the people being treated did not exhibit psychiatric illnesses:

A. Well they didn't have any psychiatric illness definitely not.

Q. They weren't really the norm then in psychiatry?

A. No, no definitely not.

This anxiety over the aptness of psychiatric treatment for drug users can be said to flow from the concern that these 'patients' were not 'sick'. For Talcott Parsons illness was not just a condition independent of the 'social'. Parsons conceived the sick role to be one where:

To be 'sick' was not only to be in a biological state which suggested remedial measures, but required exemptions from obligations, conditional legitimation, and motivation to accept therapeutic help. It could thus, in part at least, be classed as a type of deviant behaviour which was socially categorised in a kind of role (Parsons, 1964, quoted in Holton and Turner, 1986: 120-121).

Here being sick is perceived as involving a certain deviation from normal expectations:

The crucial distinction between illness and health was engagement in and withdrawal from social responsibilities in familial and occupational roles (Holton and Turner, 1986: 122).

Thus the role of being sick involves fulfilling certain social expectations such as withdrawal to the home for recovery, blamelessness for the illness, the obligation to seek out and co-operate with medical care. Thus 'deviant' withdrawal is socially controlled through motivational expectations surrounding recovery to conventional roles. It was this lack of motivation and continued therapeutic conflict that led to uncertainty in the further applicability of treatment contained in the consultant's general reflection that:

You always felt that you were almost running something illicit. There was this embarrassing feeling that you were treading slightly into no man's land.

Reservations regarding patient activism lay at the heart of a reluctance to provide inpatient services and the reason, from the psychiatrist's viewpoint, for their breakdown. However it should be remembered that the failure to establish an empathetic relationship, which led to a questioning of the patient's motivation and sickly status, might have been very hard to attain in an atmosphere of enforced conformity of prohibition/abstinence. Empathy, projecting one's personality into and so fully comprehending the object of contemplation, seems at odds with a stratum of abstract knowledge based on dangerous drugs, health values through detoxification and a relationship modelled on the renunciation of one's own will and self (see

Foucault, 1988a: 48). The consultant exhibits the conflict of abstract mentalities concerning health values and abstinence against a concern for the more practical realities of everyday policy in providing a service and containing the problem.

'Lumpen Resistance'

Whilst the motivation of drug users may have been in many cases ambiguous, their resistance to this policy technique was marked. Foucault describes 'resistance' in the following way:

These points of resistance are present everywhere in the power network. Hence there is no single locus of great Refusal, no soul of revolt, source of all rebellions, or pure law of the revolutionary. Instead there is a plurality of resistances, each of them a special case: resistances that are possible, necessary, improbable; others that are spontaneous, savage, solitary, concerted, rampant, or violent; still others that are quick to compromise, interested, or sacrificial; by definition, they can only exist in the strategic field of power relations (Foucault, 1979a: 95-96).

Foucault's theory of resistance makes it possible to advance what I believe to be a novel argument surrounding drug user reluctance to participate in policy and programmes so far described. Concentration on local centres of power and resistance shifts the focus away from large-scale protest and revolt directed against the state to more numerous acts as Foucault describes:

Are there no great radical ruptures, massive binary divisions, then? Occasionally, yes. But more often one is dealing with mobile and transitory points of resistance (Foucault, 1979a: 96).

This de-coupling of resistance from protest and state makes it possible to view resistant acts outside of politico-ideological affiliation and capable of investment in even one of the more unsympathetic and unorganised groups such as heroin users:

It can be argued that within a general reflection in terms of power the category of resistance cannot be made to exclude its (supposedly) 'primitive' or 'lumpen' forms of manifestation (Gordon, 1980: 257).

One of the original applications and arguments of this focus is that we can think of drug users in terms of resistance. The study of this resistance becomes concerned with:

The existence of those who seem not to rebel is a warren of minute, individual, autonomous tactics and strategies which counter and inflect the visible facts of overall domination, and whose purposes and calculations, desires and choices resist any simple division into the political and the apolitical (Gordon, 1980: 257).

James Scott also understands resistance as being initiated by individuals as well as groups:

Resistance includes any act(s) by member(s) of a subordinate class that is or are intended either to mitigate or deny claims (for example, rents, taxes, prestige) made on that class by superordinate classes (for example, landlords, large farmers, the state) or to advance its own claims (for example, work, land, charity, respect) vis-a-vis those superordinate classes (Scott, 1985: 290).

Again this literature is not focused on the grand social movements but on the often more local and multi-faceted patterns of resistance to the surveillance of the poor, such as the hidden economy of cash in hand jobs (Gillom, 1997). McCann and March (1996) and Handler (1992) criticised such studies for lacking any ethical framework for judging these actions, as being evasions rather than representing conflicts surrounding issues such as poverty or racism and being unrepresentative of the broader community. However, part of the importance of resistance literature is that it concentrates on the otherwise ignored low level conflicts that exist outside the realm of large protest organisations and those institutions they are often directed against such, as the state, as McCann and March do recognise:

In fairness, most scholars of legal resistance have made an important advance in decentering the state, in demonstrating how official institutions are fragmented, decentralized, and shaped by local forms of culture and citizen interaction (McCann and March, 1996: 220).

The contribution of resistance analysis can be read, with some resonance, as part of the wider ambitions of local analysis within this dissertation and to ignore this is to limit our conception of political activity:

To do this is to miss the immense political terrain that lies between quiescence and revolt and that, for better or worse, is the political environment of subject classes. It is to focus on the visible coastline of politics and miss the continent that lies beyond (Scott, 1990: 199).

Patterns of resistance were both detected and sometimes acted upon by local agents. Resistance to inpatient treatment took the form of abandonment almost as an

oppositional correlate (see Foucault, 1979a: 96) to abstinence and renunciation of will. Renunciation of the self as drug user was resisted as a technique by choosing to remain one or less likely detoxifying themselves. Drug user resistance can be seen as the forgotten other half of policy. Here is a way of explaining not just that the strategies of the war on drugs are poorly thought through but applied to a group and individuals that don't want them. In particular, regarding psychiatry, it reveals the fallacy and problems of the welfarist professional approach that met resistance on the street, in the GP's practice, on the psychiatric inpatients ward or the injection room that led to disillusionment amongst staff.

This coincided with a time period that began to view individuals and groups in terms of their patterns of consumption. Central to consumerism is the 'generation of longing' fed by a constantly reproduced cycle of novelty (Campbell, 1987: 85-87). One of the most common examples of this spirit as performed in daily society is that of window-shopping. This practice confirms that 'consumption is less about actual material acquisition than it is about producing desires' (Frank, 1991: 62). For drug users, in this context of consumerism and window shopping, fashion items and DVD players are not so much about promoting a consumer lifestyle through stimulating an experience of longing, but more as a source of money with which to increase the amount of times they can experience the stimuli of the drug. Heroin users may be viewed as 'bad consumers' because their ability to participate in the constant reproduction of desire is limited.

Analysis of resistances can be used to further investigate local mechanisms of power. It makes the depiction of control paradigms much clearer and helps explain their limits, failure and how subsequent ones develop and emerge because others fail due to this resistance. Initial resistance to inpatient detoxification/abstinence was met with a move to maintenance. The consultant already noted the likely form of resistance to this during the visit to the USA. 'Clipping' part of the supply for sale and 'conning' the supplier by alleging unforeseen loss formed another subtler resistance. However this maintenance encouraged at least partial substitution of proscribed for prescribed drugs, maintained contact and a move to a slightly less chaotic type of drug use. In

effect it could be perceived as an embryonic self-responsibilising technique of encouraging a more stabilised use whilst attempting to transform a small part of drug use lifestyle. This attempt to 'dilute' the drug lifestyle through substitution inferred an acceptance of a certain amount of unsanctioned drug use, the kind of flexibility much more in evidence amongst the voluntary organisations that utilised self-responsibilising techniques a decade later. However it should be noted that this 'containment' was not the same as the more fully formed notions of enabling techniques of self-responsibility utilised later on. Containment was more a product of disillusionment than an assertion of a different and changing mentality and practice rooted, as we shall discover, in a disavowal of abstinence theory and practical attainment.

Due to the relatively low intravenous drug using population at this time few general practitioners had any contact or experience with such patients. The summary presented below will form a prelude to a description of the much heavier involvement that was to follow in the 1980s.

GP Action in the 1970s: The Beginning of Involvement

One general practitioner at the time describes how they first came to be treating drug users:

A. I think we had one or two young males coming with so called sleep problems and they were really wanting barbiturates. This gradually became apparent. It wasn't too obvious to begin with, we took everybody at face value and were quite willing to prescribe short courses of initially short acting barbiturates like Soneryl (Butobarbitone a hypnotic/sedative). Then it became apparent from people who were rather conning us so to speak... They'd come from another practice

Q. How were your suspicions aroused.

A. Well in the usual way, frequency of attendance, not exactly demanding, but some element of insistence or persistence. Gradually more and more of the excuses....

The actual numbers of drug users being treated by this particular surgery amounted to around 10-12, quite high by standards at the time. The basic policy consisted of reduction to abstinence as evidenced by a GP working at the time:

Well initially we were trying to reduce them and get them off. Then it became apparent that we weren't having certainly 100% success, maybe not 75% success. So then it was a definite plan to try and maintain some of them, but as far as possible still to persevere with trying to reduce them with the aim of stopping them.

To reinforce this, rather than just being given a repeat prescription to pick up at the surgery desk, weekly visits to see the doctor were necessary before any drugs could be prescribed. As a last resort practitioners could threaten and indeed remove the patient from their list, or at least their prescription list. As the number of practitioners willing to treat drug users was limited to a few surgeries during this period there was a 'drift' effect noted by one GP:

A. One became aware others had joined the practice from outwith our usual practice area. They thought they would obtain prescriptions that their own previous doctor was not willing to supply, or because they didn't want to have the same doctor that their parents had. So we did become more and more aware that people seemed to be drifting towards us and so we had to clamp down on that.

Q. Was this by just refusing to take them onto your list then?

A. Yes I'm afraid we had to use reasons such as the list is closed [full up], that was the usual.

Despite claims of high reduction success the practice continued to attract users searching for drugs. In the doctors surgery policies of reduction, detoxification and maintenance, co-existed rather than representing discrete historical phases. The process of reduction in this doctor's surgery was characterised by a rather indefinite schedule as regards the time these measures should take as distinct from the initial fixed term detoxification of the psychiatric clinic. Patients were rejected where they were there solely to con drugs but such rejection may owe just as much to inability, administratively, to cope with being a 'popular' surgery for drug users together with an early concern that the management of this group should be more broadly shared.

One of the differences between GPs and their psychiatrist colleagues was that the former were subject to a certain level of outside scrutiny and control. Both the Drugs Squad and the Home Office Inspectorate could apply, often informal, mechanisms of control over prescribing GPs. The Drugs Squad's 'policing' of doctors will be elaborated on in the next section of this chapter. The Home Office Inspectorate were responsible for monitoring the level of prescribed drugs by reviewing the records of chemists. Inspection of these records also revealed the origin of the prescription note, which doctor had written it and for how much. Where the inspector felt that the

amounts being prescribed were too much or too frequent they would request an interview with the doctor concerned. In extreme cases the inspector had the power to remove or suspend the doctors right to give prescriptions for certain drugs. One doctor, in the following, describes the kind of regulation and relationship between GP and Home Office Inspector:

Q. Would you always agree with them [the inspector] or would you disagree with them?

A. Oh [we] wouldn't always agree with them.

Q. What would happen when you disagreed?

A. Oh they were all very polite..... we had the impression that we had better be careful or we might be up in front of some kind of disciplinary committee. ..[They] were not exactly threatening but would express their displeasure at what they saw as, if they thought that we were tending to be patient led in our prescription.You sort of felt he was a civil servant and he [was] in fact not going to stay in that post for a long time. Whereas we were on the ground and hopefully going to be in practice until retirement. So our policies, in some way shall we say, were directed by a knowledge that we would always be there. Whereas the inspector would be moving on.

Q. So what differences did this lead to?

A. I got the feeling that his ideas of treatment shall we say...were perhaps difficult to put into practice.

Q. What were his ideas?

A. I suppose more stringent prescribing or maybe less frequent which in an ideal world would be a natural choice.

These discrepancies between doctor and inspector reveal the ambiguity between a policy of reduction and maintenance in the surgeries. The doctor was clearly convinced that they were pursuing a policy of reduction using temporary prescription of substitute drugs as a way of ensuring contact. The inspector's opinion implicitly questioned whether this wasn't erring towards maintenance on certain occasions. This can also be interpreted as reflecting the ambiguous character of the control being used by doctors in local practice. It also signifies a certain amount of tension between local pragmatic policies and more remote centralised ones. In the decade that followed this local pragmatic reaction, amongst some GPs was to grow in significance.

Another body that would grow in both its numerical strength and its impact on drug policy was the Drugs Squad. During this early period, covered in this chapter, the Drugs Squad remained a small unit subsumed within a still relatively minor arm of the constabulary. This did not mean that it could not generate significant change from within its local base.

Policing Edinburgh's Intravenous Drug Users

The policing of drugs in the 1960s/1970s was confined to a small group of officers in the Aliens, Firearms and Dangerous Drugs Department, originally based in the High Street then later moved to Fettes Police Headquarters. Around this time there would typically be two teams of two officers (and one chemist officer²) working alternate weeks of back shifts (4pm-midnight or 6pm-2am) on the streets and day shifts doing paperwork. Chemist shop break-ins occupied the majority of the groups time along with some work in connection with doctors prescriptions.

Chemist Shop Break-ins

The main preoccupation of the Drugs Squad from the late sixties to the end of this period was in solving chemist shop break-ins. A serving Drugs Squad officer gives an idea of the scale of the problem below at the time:

We had a large number of chemist shops broken into in Edinburgh. We had a team operating in Edinburgh of probably about up to 20 junkies in those days who were capable of breaking into chemist shops. You could take any two or more from that group of 20 [who would break-in].

Thus roughly half the estimated amount of intravenous drug users were seen by the Drugs Squad as being 'in the picture' as regards chemist shop break-ins. As indicated it would be likely that a small group of say four would be involved in any one break-in. The actual occurrence of these break-ins seems to have been quite prolific as another experienced officer admits, "Oh in those days it was regularly, you're talking one a week". Chemist shop security at the start of this period was a personal matter for the chemist. Throughout Edinburgh chemist shops were being broken into overcoming what security there was in place:

All over Edinburgh, they were quite professional. They would go out, they would have a recce of the shop, if it had good security. If they were good professional thieves they could overcome virtually any security they wanted. I mean at the end of the day they could just knock in the front window and run into the shop. But as a rule they would prise open bars with car jacks, they would do things like that. See the value of the drugs to the chemist was negligible, but the value of the drugs outside was enormous, as it still is.

² The chemist officer (a position in Edinburgh dating from 1923) would check the supply from wholesalers to chemists and tally this against the sales made and stocks held by chemists.

These break-ins were not restricted to the Edinburgh area. The Drugs Squad were involved in following the exploits of this highly mobile group around the country and on occasion down south to England as the following extract reveals:

Honestly they travelled the length and breadth of the country. On one occasion I was present, we actually joined up with the Scottish Crime Squad, and we followed a team who were going to break into a chemist shop. We left them because we were running out of petrol and there wasn't an all night petrol station. We left them at Gateshead and the Scottish Crime Squad carried on the follow and they were eventually taken down to about York and they were stopped. That's the sort of distances they were travelling to break into chemist shops. They were up in the Western Isles, they broke into chemist shops in the north of Scotland and all over. We used to get telexes from all over the country...but quite a lot of the times we would catch the culprits and surprisingly you would be able to tie in the drugs or other contents they'd got from the shop....it was worthwhile forces phoning us.

With the limited size of the intravenous drug using community there was a good chance of detecting the offenders. Some sources of information that helped in this, the police maintain, came from drug users themselves as the following reveals:

A shop would get broken into, you'd get the report when it came in the morning and either you would go out and knock on a couple of doors or wait on a phone call to come. Somebody would be complaining, somebody had been offended or bumped for cash, never got good value for money. Because we were an integral part of the drug scene we would get phone calls.

The use of paid, or unpaid, informants was widespread and deemed to be effective for the reasons explained by an ex-Drugs Squad officer:

You'd put word out amongst folk, amongst your informants, that there was a chemist shop done. All that would happen is they would look amongst themselves as to whose got a load of dope, who is smashed out of their heads all the time.

The Drugs Squad would then either raid the house or maintain surveillance in order to find out where the main cache of chemicals had been hidden:

They would stash gear, but they would take what they needed back to the house. So if you knocked off the house you found something, down a toilet hidden in the house. I mean if they were out of their skulls when you arrived they obviously had something and all you had to do was use subterfuge and wait and eventually they had to get out.

Concern amongst Drugs Squad officers at the number of these break-ins reached such a point the Drugs Squad started to informally 'lobby' for a harsher response to pharmacy break-ins. This produced the following change:

Policy-wise in those days the actual number of break-ins was causing such concern and the after effect of it was causing such concern to senior officers. We were generating that concern, we were saying this is happening and the bosses took it on board to contact the Procurator Fiscal of that day, who arranged a meeting with the Sheriff Principal. It was agreed that anybody who was caught within the Lothians area, as it was then the Sheriffdom of the Lothians, anybody who was caught for breaking into a chemist shop in the Lothians would no longer be put on summary complaint they were going to go on petition.

Not only were the potential penalties increased for this particular method of illegitimately obtaining controlled drugs but the conditions of bail would be changed:

It was agreed anybody going on petition would be remanded because that was part of the problem. They were getting locked up one day, they were out the next day and they were just going out and re-offending the same night.

These policy changes, of increased penalties and additional restraints, took place on a purely local basis and in a highly informal manner as one officer confirms:

I think it was an agreement by word of mouth. I don't think there was any paperwork or any memos.

Drugs Squad policy during the 1970s was characterised by its deployment of techniques of traditional domination informed by the mentality of prohibition. The most common form of resistance, taking drugs stolen from chemists, established a local linkage between drug use and conventional theft that attracted increased surveillance and 'criminalisation'. The changes that took place in policing drug users can be seen to be the result of the local context of 'drug crime'. In turn the counter-measures taken can all be seen to have been a result of locally orchestrated action, from within the drug squad, on the streets. This has a great resonance with Collison's analysis that not only does the Drugs Squad have a great level of operational autonomy but an equal ability to influence and set policy agendas where it counts-'on the street' (Collison, 1995: 12). Another concern, although of lesser significance, to the Drugs Squad at the time, were drugs that were obtained by drug users from doctors; either by conning them or stealing prescriptions and subsequently forging them. This

increased 'criminalisation' was the beginning of a long-standing association between drug use and crime in its plainer form. These techniques of law enforcement and its irreducible oppositional resistance characterises the construction of power relations of law and drugs:

Where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power....This would be to misunderstand the strictly relational character of power relationships. Their existence depends on a multiplicity of points of resistance: these play the role of adversary, target, support, or handle in power relations (Foucault, 1979a: 95).

Thus the continuing problem of drug use entered into a relationship of adversary, target and support for Drugs Squad actions. As we have already seen there were other ways that users illegally obtained drugs. One of these was through deception of general practitioners. Here police had to take a less direct line in how they tackled the 'source' of supply.

Policing General Practitioners

Medical prescription of barbiturates to drug users never represented a major problem in terms of the number of times this practice necessitated Drugs Squad intervention. There were however certain times when concerted action to stop periodic outbreaks of increased supply onto the illegitimate market was taken. An officer involved describes one such instance below at the time:

The one that sticks in my mind, was.... up in Gardener's Crescent. We had a severe Diconal problem at the time. Everybody up the Tollcross area was all going round with pocketfuls of this. It was all coming back to him ... So we went to see him and said look this is a problem...and we're saying well now you've got a whole area of town with pink lips. ...He'd put himself under pressure by prescribing. We approached him informally but he didn't take our advice and I think the Home Office procedures were invoked. If a gentle word in the ear didn't work then we just snapped into formal mode and the Home Office Inspectors came up here and policed him.

This ultimately rather formal, in the end, approach to policing doctors who prescribed was not the norm. More often than not, what seemed to happen was that the Drugs Squad would pay an informal visit to the doctor concerned and either ask questions relating to a patient or make the GP aware of certain facts that might 'affect' their

treatment. The following provides a summary description of these relations provided by a prescribing doctor working at the time:

A. We didn't have so many meetings with the Drugs Squad. It would usually be because in connection with a certain individual not the whole.

Q. What sort of form would that take?

A. They would just come..... to check up really on the individual's statement or to inform us of facts or events that we weren't aware of.

Q. Such as person's amount of drug use?

A. Yes or the usual complaints from chemists or maybe some involvement with the police.....They didn't actually sit down with us and thrash out a common policy. I think they just really wanted to develop a heightened awareness on our part of the current scene as they saw it.

Q. What sort of things would provoke this intervention. Was it just the odd patient that got out of line?

A. Yes and one thing would lead to another. Obviously I think from time to time of course they would check the chemists prescribing list because they had the powers to do this.... Gradually they build up a picture of the prescribing pattern and individuals involved. So some of the visits, that weren't all that frequent, were of the warning nature. Perhaps from their standpoint they were worried about over-prescribing or any tendency that way.

Once again then policing, of general practitioners, was very much one of locally negotiated control. Whilst there remained instances where the formal apparatus of centralised Home Office bodies was deployed, usual procedure was handled on an informal pragmatic basis through persuasion and increasing the vigilance of prescribing pushing it closer to prohibition.

During this period the Drugs Squad were rarely involved in the policing of heroin imported into the force area, other than that stolen from chemist shops outwith the region. Drug importation from abroad was not perceived as a major problem:

We occasionally came across morphine or heroin from abroad, not the pharmaceutical stuff.

The Drugs Squad would, however, go out to Turnhouse [Edinburgh] Airport on occasion and watch the last plane in from London. The squad was aware that a very few drug users would go down to London for a couple of days. They would return on the last flight. The passenger could book a standby seat but did not have to leave a name and could be paid for in cash just before departure. This sort of operation was not part of an ongoing surveillance.

The Drugs Squad, aside from informally policing GPs, had little contact with the other medical agencies concerned with drug policy at this time. One Drugs Squad officer working at the time summed up the mood prevalent in the squad:

In these days we didn't have much contact with them [medical staff] because there was a great gulf. We built a wall around ourselves and were suspicious of everybody because as policemen we felt the drugs problem was a law and order problem. Medical people felt that its not a law and order problem, its a medical problem.

This 'territorial' view was reinforced by a dismissive view of psychiatric treatment:

We were cynical, well nobody ever gets better. Which in these days very few people did, I know that to be fair...We just tended to think, well they'll go there and they'll be missing off the streets and we'll catch them when they come back out.

With this view of treatment there was little incentive for contact with staff at the Psychiatric Department, let alone for any co-ordinated inter-agency approach. The consultant in charge at the time confirms this gulf:

I mean I knew them by name and from time to time they'd come up but there was no linking....not even in terms of trying to work out a policy. I don't think, I honestly can't remember whether they knew or didn't know how I was prescribing. I don't remember having any special meetings.

Intravenous drug policy during this period was largely reflected through externally validated morals and obligations be it with reference to the sick role or legal order. This 'moral government' through objectification insisted on some form of renunciation informed from more abstract truths concerning law and order or dangerousness and abstinence. Little redress at this time was made to the practices or techniques of self-reflection and self-management as local policy extended old arrangements with increased criminalisation. However within this moral domain smaller activities of maintenance, within psychiatry, and an amount of open ended prescription amongst GPs, whilst not examples of fully formed strategies that encouraged self-responsibilisation, did provide examples of a distinct bending of policy, generated within the local context, towards a more pragmatic everyday reality. These small spaces of indeterminacy would be superseded by a greater outgrowth of such contingency running alongside existing monolithic arrangements as the problem worsened in the next decade.

Even at this early period it has been demonstrated that drug policy in Edinburgh was often initiated and formed from the ground-up. The primary psychiatric treatment facility was run on a small, almost individual, isolated level. Changes in policy, in part response to local drug user resistance, were neither monitored nor censured along central or even local hierarchical lines of control. The move from abstinence and detoxification to prescription maintenance, the albeit short lived injection rooms and all other treatment initiatives, were essentially formed and determined at the city level. In addition the few general practitioners involved with drug users operated in large part quite independently at the local level. Where GPs were subjected to outside control this came, with few exceptions, not from centralised medical bodies but involved negotiations with local drug law enforcement. Lastly policing policy was formed where it was enforced and mattered-at the street-level. The mentalities and conceptualisation of the drugs problem and the changes to tariff and bail requirements these brought about originated from within Edinburgh's Drugs Squad. Power relations and policy formations, its intention and investment in practices, was even by the 1970s significantly rooted in the local Edinburgh landscape.

Equally this chapter has demonstrated that there were a range of responses in drug policy at the city level. Whilst treatment mentalities and models moved from abstinence to containment, law enforcement ideals stood firm and even intensified an already prohibitionist approach. The mutual isolation and to some extent cynicism, limited direct confrontation but it did not mean that local policy was not a contested issue. Rather it meant that two approaches began to evolve and inform drug policy in Edinburgh. This local difference, as the next chapter will demonstrate, was to diverge even further when put under the increased strain of escalating heroin use.

CHAPTER 3

COMMUNITY POWER: The local development of criminalisation and self-responsibilisation

This chapter begins with an examination of the characteristics of the first real heroin epidemic in Edinburgh. This defining change in the local drug scene provides the context through which policy reaction can be viewed. The chapter then shifts to a detailed analysis of what that policy reaction was. It is argued that these, often ad hoc, initiatives continued to be formed, during the early 1980s, from the ground-up. Subsequent sections reveal how different agencies contributed to this expansion of a local centre of policy action. Analysis of national Advisory Council on Misuse of Drugs reports further confirms this trend. Additionally this chapter argues that another significant movement in drug policy becomes identifiable during the early 1980s, namely the emergence of new techniques of self-responsibilisation discussed in Chapter One. Together with the intensification of existing methods of criminalisation, policy formation within Edinburgh continues to be one of a contested nature.

Changing Drug Scenes: The First 'Epidemic'

By the early 1980s there was a significant increase in heroin use in Edinburgh and elsewhere in the UK. Even Burr's (1983) description of the pharmaceutically-supplied Piccadilly drugs scene of 1979 began to acknowledge a change with new networks that dealt in imported powdered heroin, possessing greater structure with regular contacts (1983: 90).

The reasons for this increase are often perceived as being diverse and somewhat difficult to assess in terms of causal strength. First, certain political changes in what has been called the 'Golden Crescent' area of south-west Asia had a profound effect on the global heroin economy. For example the change of regime in Iran in 1979 brought about an exodus of the Shah's supporters and their wealth which was

sometimes converted into heroin for re-sale on the markets of Europe and America as Lewis claims:

It was evident by mid-1979 that some wealthy Iranian exiles, particularly in London and Los Angeles, were moving their capital in the form of heroin rather than gold or other commodities. The involvement of SAVAK [the Shah's secret police] and members of the ruling elite in the traffic had been rumoured for some years, both in Iran and Western Europe (Lewis, 1985: 41).

This, added to the conflict in Afghanistan and increase in the trade of heroin-for-arms in that country and neighbouring Pakistan, meant that the late 1970s early 1980s saw an increased volume of heroin supply on the world market.

On the demand side there have been some studies that have commented on the relationship between economic decline at this time and the increase in the use of heroin. Parker et al. (1988) studied the growth of heroin use in the Wirral area of England. They surveyed the records of official agencies and cross-matched the 'known' users with the results of interviews conducted with 'unknown' snowballed networks of users (Parker et al., 1988: 12). Of the sample they found 81% were unemployed. Correlations were found between heroin use and seven indicators of social deprivation including unemployment and housing type (1988: 18). However, these were only correlations and fell short of casual evidence as the researchers admitted, although they clearly felt strongly about the nature of the connection between deprivation and heroin use:

Although such correlations do not amount to conclusive evidence of a causal relationship between opioid use and social deprivation, they do indicate a stable association between variations in the two phenomena over time (Parker et al., 1988: 39).

Peck and Plant conducted two separate studies concerning unemployment and drug use (Peck and Plant, 1986). First they interviewed a cohort (n=1036) of young people from the Lothian area in 1979/80 and the same group in a follow-up sweep in 1983. Data on employment status and the use of illegal drugs, alcohol and tobacco was collected. Secondly the researchers looked at official statistics of unemployment (average annual unemployment) and drug use (cautions, convictions and addicts reported to be receiving notifiable drugs during treatment for their dependence) and any resulting comparable trends found. Unfortunately the study was concerned with

overall drug use and not heroin use in particular. Despite a lower unemployment rate in the Lothian area than the national average for the age group the researchers found that the duration of unemployment of those unemployed in 1983 was 'weakly but positively associated with the number of illicit drugs ever used and with the number of drugs that are classified under category A of the Misuse of Drugs Act 1971' (1986: 930). When analysing UK patterns of unemployment and drug offences the authors found, despite the accepted limitations surrounding all the official statistics examined, correlations between unemployment and the two official drug indicators (1986: 930-931). However, as the authors pointed out 'Association does not necessarily impute a causal relation...It would be naïve to contend that unemployment is the only cause of illicit drug use' (1986: 931).

Surveys conducted into heroin use in Edinburgh, such as by Haw and Liddell (1986), does not show evidence that higher levels of deprivation cause higher levels of heroin use. That the availability of heroin increased during this time seems clear. It may be noted that many of the grassroots agencies that first addressed the heroin problem in Edinburgh were grafted from existing projects involved in youth and unemployment issues as were many of the staff. Many of the observers at the time seemed to have shared a common perception that the problem was rooted 'within neighbourhoods which are the worst affected by unemployment and wretched housing' (Pearson, 1987: 4).

The availability of reliable statistics is limited partly by the esoteric nature of drug use and by the few contemporary studies carried out. Two of the most useful surveys conducted point to an increase in drug use of 'epidemic' proportions. A study by Robertson and Bucknall (1986) analysed data collected on patients attending a general medical practice, then called the West Granton Medical Group. This medical group practised in one of the most deprived areas of Edinburgh serving a population of 17,000, with 7,000 patients, predominantly from Northwest Edinburgh. Robertson and Bucknall recorded an increase from approximately 20 users, attending their practice, in the 1970s to 230 individuals by the end of the research date of June 1986 (Robertson and Bucknall 1986). Sally Haw and David Liddell (1986) conducted the only other substantial fieldwork survey of drug problems in Edinburgh, for the

Standing Conference on Drug Abuse (SCODA). Their report (1986) sought to provide an assessment of the levels and patterns of drug taking in the Edinburgh District. By examining a range of agency indicators, a statistical account of the characteristics of 'problem drug takers' was constructed. In the authors concluding comments they arrive at an estimate of the scale of the problem:

Examining the overlap between the SCODA Index of drug takers with those known to the Edinburgh Addiction Study, suggests that the SCODA Index might underestimate the number of cases by at least two, giving a minimum problem drug taking population of about 2,000 of whom at least 75% would be opiate dependent (Haw and Liddell, 1986: 66).

The researchers also attempted to identify the distribution of problem drug takers. They found that according to their indicators the distribution of drug users was firmly within the poorer areas of the city. They went on to illustrate this with the following detail:

From these figures it is possible to see the development of the now characteristic X [shaped] distribution of drug cases within Edinburgh District. The composite map for the years 1979-84 shows this particularly clearly, with Muirhouse in the north-west and Craigmillar in the south-east highlighted and forming one diagonal and the other formed by a band of problem drug taking running from Leith in the north-east, through Carlton and the city centre, south westward through Gorgie, Stenhouse and Sighthill to Wester Hailes (Haw and Liddell, 1986: 42).

Prevalence rates (cases per 1,000 population) amongst 15-35 year olds, in individual areas, reinforced the findings of the overall distribution pattern. The male prevalence rate for Leith (EH6.6) was 36, for Muirhouse 29 and for Craigmillar 20. Female prevalence rates however were still high, Leith with a rate of 22, comparing with many of the higher male rates in other areas (1986: 45). These rates were considerably higher than the mean male rate of 8 for Edinburgh as a whole (1986: 45).

Caveats must be placed on these figures. Despite the breadth of data collected from the indirect indicators of Home Office notifications, psychiatry and accident and emergency services and police statistics the authors still felt unable to produce a reliable estimate of prevalence or project a total population (1986: 33). The authors felt they may have underestimated the number of users in comparison with Robertson and Bucknall but could not substitute an alternative methodological calculation. Again familiar problems surrounding notification to the Home Office either due to lack of contact with users, especially females with children, or their own anxieties over index

confidentiality (1986: 9) were noted as inherent to this project. However the overall picture provided by this data should not be discarded as it showed overlapping trends that confirmed the scale of the problem and its distribution.

The following qualitative account, based on interviews, both reinforces and gives a fuller picture to the statistical one already provided of some of the changes occurring during this period and how heroin use expanded in Edinburgh. Whilst this is not an attempt at a detailed local ethnography of drug use the following sections will contribute a fuller and subtler depiction of the social problem within which the local context of policy formation evolved. These changes in the Edinburgh drug scene include the introduction of a different type of heroin, a perceived difference in the type of dealer, together with a significant increase in the number of users already mentioned.

Evidence of a new type of brown coloured heroin, associated with increased importation into the UK, and its distinct qualities of requiring citric acid in preparation for injection are recalled in the following extract of an ex-user's first experiences of this procedure:

A. And I remember the first time I saw that happening.

Q. Was that the brown powder?

A. That's the brown, or even some of the imported stuff from these countries weren't always brown but the majority were the brown stuff right.

Q. Was this in London?

A. In fact this was in Edinburgh and er like nothing changes. I got the spoon out and all of a sudden the guy goes "where's the lemon?" You got to put lemon juice in it or something like that or it will no' break down. That's a new one on me. So ah'm watching this and he squirt ae lemon and sure enough you could see it dissolving in front of your eyes. Just the same route after that into your syringe and in you go.

The Drugs Squad also perceived a difference in both the type of heroin and the dealer/supplier as a serving officer at the time noted:

The change would probably have started '79/80. We would start to pick up non-pharmaceutical heroin. This is a personal view, it was the Leith criminals...mainly in the Leith and Muirhouse area, the waterfront section. These guys, petty thieves, put their heroin out amongst other petty thieves. At that time unemployment was just starting to pick up, so you have social deprivation [with] heroin appearing. That created the Leith heroin problem which just picked up pace.

The Drugs Squad no longer perceived heroin supply as associated with drug users but with professional criminals who had moved into a more lucrative product. Thus an organised criminal milieu became embedded within the drug scene which in turn became defined by the squad as a more criminal network.

Changes in patterns of use and distribution from the 1970s to the 1980s can be perceived through the illustrative set of experiences of one drug user/dealer. The first two extracts relate to their involvement in distributing drugs in the 1970s. This interviewee started working in a centrally located shop in 1974:

I started work.....and it turned out the manager of the place was sort of a friend of a friend of a friend. He was part of the crowd anyway. He was the manager [and] his assistant manager.....bit by bit over a few weeks these two between them staffed the place with people that they knew who were college students, down and outs.....we did have extra-curricular activities.....the place got quite well known in a quiet sort of way for hash and sometimes acid and eventually smack sort of dribbled in through various other sources friends of friends.

Q. So what were you selling then was it just mainly hash or was it heroin as well?

A. Bits of everything, I mean I would say hash was the most and acid and smack second equal.

Q. So how were they doing it, what would happen would it actually take place on the premises?

A. On occasion yes or you would meet in a pub round the corner. Quite often the deals were done over the phone and arrangements made to meet so and so at the end of the road when you finished your shift. Or somebody that was leaving or going out to post letters or something would just nip in for you because we knew each other there was mutual friend things.

The heroin-using clientele, in this network, in 1970s Edinburgh were usually employed and did not seem to one interviewee to be hardened addicts but instead more accurately recreational users:

For the people I was mixing with it was I don't know it was like coke [cocaine] is now. It was businessie people that were using it, bus drivers, taxi guys, telephone engineers, a lift mechanic, a t.v. engineer, students, a teacher, a doctor's husband, a sort of 'now are lawyers' people. I don't know if it was just the people I mixed with were more up-market for want of a better word than the sort of scheme drug addicts. It was a sort of recreational thing rather than going out and stealing things and selling jumpers round the doors 'til you got the money to go and score. These people were already working and the work they had was good enough to keep the habit and maintain the normal life style.

Approximately four years later, after a period of two years of abstinence from 'hard' drugs, the interviewee was reintroduced to heroin whilst sharing a flat with two other friends:

A. They had dealings with chaps in Leith who were like the family in Leith. ***** used to repair the door every time the ***** got busted so he was getting freebies and good deals. So it was easy to get ***** to run down to Leith and have a chat and he'd come back with a really good deal...It just kind of multiplied around this time.....By 1980 we were well established dealers we had 8 houses in Edinburgh.

Q. That you dealt to?

A. Yes like ***** and myself separately or together whatever would pick up several grams anything between 7 and 28.

This network of drug dealing within Edinburgh became quite extensive as the ex-user describes above and quite diversified in the areas drugs were dealt from as the same ex-user relates below:

Q. Where were you dealing to? Was it just local?

A. No no we had a house in ***** [Newtown (a middle-upper class residential area)], we had a house in ***** Street [also Newtown], we had a house in Meadowbank, we had a house in ***** Stockbridge, we had a house in Sighthill, one in Broomhouse, one at ***** Street [central Edinburgh]and a house in Muirhouse.

Additionally this same dealer together with another partner in crime sold to different people using different tactics in the areas they sold in:

Q. These people that you were dealing tothis wasn't like the same crowd that ended up taking it in Muirhouse and so on? Were they the same type of people you were talking about when you were talking about working people?

A. Well both actually, because we worked quite well. My house it was phone only, certain codes of phone calls and things and nobody came to my door it was all done through the phone or word of mouth. ***** by this time had a house in Muirhouse which was used purely as a shop basically and he spent most of his time up there when he wasn't at his work...I mean a lot of the stuff from New Town we did from two flats one was mostly done by a girl..[she] allowed the flat to be used as a come up and score place.

The amounts of money that could be involved even by standards twenty years ago were quite substantial, as were the potential profits as the same ex-user outlines:

Q. So how much were you supplying to her roughly?

A. Probably about a couple of ounces a week and that's I mean 60 grams say....

Q. How much would you be selling that at then?

A. Well a gram to sell was £120 although if you were buying a gram straight off it would be maybe £95-100. We were getting it for £50-60 a gram and then just handing it over passing it on. We were getting £60 profit on each gram or in most cases if people were just buying one it was dearer than if they were buying four but we ended up at one point we picked up 36 ounces I mean that is thousands of quids' worth but we got itbecause we were trusted.

When asked about the method by which users were administering their heroin the same ex-user confirmed that the majority were injecting although variance in the method was reported:

Q. What were most people doing the people you were supplying to?

A. A combination, a lot were injecting but I would say 65% injecting, 25% smoking it and the others were snorting it.

Q. They weren't all injecting?

A. Oh no I mean some people had tried injecting and didn't like it or they couldn't do it themselves so they resorted to smoking it.

The interviewee was also able to buy outwith Edinburgh to some extent:

I did a run with ***** to Manchester a couple of times a month on occasion just to pick up.

The above set of quotations reveals many important points the most important of which is that the distribution of drugs although concentrated in some of the housing schemes of Edinburgh was not patterned exclusively so. Houses were used all over the city, including those in the residential areas of the middle classes. From passing on small deals of (mainly) marijuana to people, the individual in time began to handle larger deals, sometimes involving thousands of pounds worth of heroin. Even so the structure of supply was quite direct in the sense that the user was only ever one step away from both the main city supplier (or at times an intermediary) and the street level user. It also indicates that they had been in the 'scene' long enough to be trusted and that at least some of the dealing networks were established within a small circle of friends. This was seemingly how some user/dealers came to escalate their dealings in drugs, sometimes by chance encounters, by using their experience, 'credibility' and connections to establish small networks of their own. Through inclusion of other friends they secured the source of supply and then passed this on to others to sell to whom they wished; all the time remaining for the most part one step removed from the most hotly policed areas on the street. They were thus neither the focus of attention as regards bringing the heroin into the city, even if they did go on the occasional 'away day', nor were they as likely to become the object of interest to those observing the 'street scene'. In certain respects they may not be as important as the numerically greater street dealers or the persons who brought the heroin into the city, but they form a key linkage between the two whilst as has been seen capable of turning their hand at importation or street dealing. The flexibility of such groups shows that some dealers operated at more than one level and whilst not the most common, reflected the way connections could be used in times of growing use. Lastly,

it would appear from the experiences of this interviewee at least, that not everybody injected heroin. Whilst the majority did inject, different patterns of use not only exist from city to city but within a city.

A similar pattern of supply and distribution within Glasgow was alluded to in Haw's study suggesting that the main hub of supply revolved around individual cities, with connections outside to London and further afield; 'It is widely believed amongst those interviewed that much of the heroin available in Glasgow was purchased by Scottish dealers in London, although some probably comes directly into Scotland from abroad' (Haw, 1985: 80).

Haw also suggests that this is then broken down along similar lines to those already explained (1985: 80). Thus the scale of a drug enterprise is rarely greater than the city level in which it is located. Indeed because dealerships often spring from specific local communities (1985: 80), such as Leith, control of the distribution of drugs may more correctly be seen as being based at a neighbourhood level rather than at a city-wide level.

Other agency workers also noted this increase in the amount of heroin use in the early 1980s. A local social work resource worker at the time described the increase from their experience:

79/80...I would put it at probably [19] 80 really before it became very apparent that most of the people I was working with were using heroin. They had been using it for some time [because] they'd begun to get caught for it....It came out because a problem arose from that they got caught for stealing or possession or dealing or something like that.

The dramatic increase in heroin use in the 1980s can also be illustrated by the observations of drug users. One heroin user, returning to Edinburgh at the time, recalls the change in the availability of heroin:

Oh aye I was bumping into people that I never seen in my life before like so and so will be able to give you a bit 'Dave', 'Bruce', if you cannae get any go through to.....aw aye the availability of smack then was like being able to go out and buy a carry out at an off licence, common place now. As opposed to when I first started taking it maybe tops three dealers in the whole of Lothian never mind Edinburgh.

A second interviewee reflects on the spread of the street dealers in north-west Edinburgh. These dealers were the lower end of the drug dealing market. They would often be using the drug and dealing to support their intake:

I think it escalated '79/80 because you could walk along a street in Muirhouse or West Granton or Pilton and if you knew anything about the drug scene you could point out the exact flats where people were dealing. It would be two or three in the same stair and it got to the point where you could walk along any road in the whole of the housing scheme and you could guarantee that there were at least two or three dealers in that street...it was quite funny from our bedroom window we could see a chap who was dealing for the same chap as us.

Outside Edinburgh, Ditton and Speirits (1981) recognised a similar 'rapid increase' of heroin use in the early 1980s in Glasgow (1981: 3). Significantly the heroin use had moved from the more middle class West End to more dispersed neighbourhoods going 'out onto the streets', whilst users had become younger, fewer of them having jobs (1981: 12-13). Haw's study (1985) of 'Drug Problems in Greater Glasgow' conducted in 1983 confirmed much of Ditton and Speirits' findings, including the growth of the black market and the younger users' illicit funding of their habits (1985: 11-12). One very approximate guess estimated a user number of 4,300 (1985: 59). She was less equivocal about the changing pattern of distribution:

The majority of opiate users would appear to come from the North and East which form a band which runs around the city centre from Maryhill in the North East to Gorbals just South of the city centre. There are also three communities on the very outskirts of the city, G34 to the East, G45 to the South and G15 to the North West. The similarity between the opiate maps produced and demographic maps of the city, are unmistakable. Quite clearly the majority of identified opiate users come from poorer areas of the city (Haw, 1985: 53).

Parker et al.'s (1988) study of the Wirral found high rates of use amongst 16-24 year olds (18 per 1000) and the unemployed (28 per 1000) (1988: 15-16). The authors additionally hypothesised a link between growth in acquisitive crimes, above national averages, and the funding of heroin use. Pearson et al.s' (1987 conducted 1985), rare, regional study found use a 'scattered and localised phenomenon with profound local variations particularly between sites west and east of the Pennines' (1987: 5). Brown and Lawton's (1988) 1986 research in the Portsmouth and Havant area found use may be lower than national levels (1988: 26) or certainly no larger (1988: 138) with little indigenous distribution due to its proximity to London (1988: 16) thus reminiscent, supply wise, of findings elsewhere of a decade ago. These studies suggest that the

type and scale of heroin use was often mediated by location. The localised scale of heroin use would, for example, almost certainly influence the amount of drug related crime and police response. Again the type of drugs predominantly used, and in later years how they were used (by injection or not), would again influence the local service response.

Along with an increase in use and organisation of the drug scene in Edinburgh came an increase in the levels of violence associated with the illegal drugs market, inwardly directed among users and sellers. Violence would stem from many sources including disputes arising from competition, petty squabbles over drugs, action taken by vigilantes, and other people trying to break into the business of drug selling under the pretence of vigilante action.

The following extract, from an ex-drug user, gives an example of violence arising as a result of competition for 'clients':

He'd score off us and then he'd sit at the bottom of his stair and say 'oh dinnae go up to **** cos I've got gear and my gear's better than theirs'. He was selling them like reduced packets of our gear. Eventually he got a panelling, he got beat up for it, because you didn't do that, you didn't poach people's customers.

Additionally there was evidence of action taken by ad hoc vigilantes, recalled below by a then serving Drugs Squad officer, to 'solve a problem':

A guy overdosed in his house...and I'd gone up to the house to have a rake through the house....all standard police practice. All of a sudden the door came in and there were about 8 guys standing there, metal bars the whole thing. That's when you find out what colour adrenaline is. What in fact happened, this was his work mates, he was a middle of the road guy, job the whole thing. By that stage the heroin problem had gone into the general population and this was them thinking we're going to sort out who had supplied him because they thought he was in the house. We got the whole thing resolved. In actual fact these guys went out and found out who it was and phoned in and said right there's the direction. Certainly the guy got a thorough going over from the work mates.

With increasing use and greater money to be made, more violent methods began to be used. The dealers of drugs were far from immune to others moving in on their trade in a sometimes extremely violent manner as one interviewee retold:

He was I dunno part of the organised crime scene rather than the drugs scene.....It turned out that he was petrol bombing people's houses that were dealing, beating them up and nine times out of ten once he'd beaten the person up he would get them to sell drugs for him.

Protection of heroin obtained or drugs sales, became a focus for much of the increase in violence over these years. The situation was summed up in the extract provided below, by a Drugs Squad officer:

Violence goes hand in hand with that whole scene. It was a violent society because if you have begged, borrowed, or stolen the cash and then somebody has come along to steal [the drugs] you're going to protect it with your life.

Having examined the increase of intravenous drug use in Edinburgh in the early 1980s attention will now be turned to a brief examination of the official response at the national level, contained in reports such as those prepared by the Advisory Council on the Misuse of Drugs for the then Department of Health and Social Security. It should be noted that these reports reflect and confirm the significance of the ground-up approach and specifically deny the advisability of a national level policy. It will be argued that these reports are following what was then already happening at the local level.

NATIONAL ADVICE AND OFFICIAL TREATMENT

The first report from the Advisory Council on the Misuse of Drugs (ACMD, 1982) during the eighties noted and expressed concern with the recent changing patterns of, and growth in, drug misuse in the early 1980s. In light of this the committee assessed whether the then present system of treatment services were adequate to the task. It reviewed a number of approaches to treatment making only specific recommendations regarding prescribing policy, medical training, research and funding. The group also advised on the future development for the framework of services. Within this paper the authors more than once were at pains to point out that an overarching UK national policy applicable to the services was both impracticable and inadvisable:

We are aware that the variety of treatment styles and rehabilitation strategies causes some individuals to call for a national policy to clear up misconceptions and standardise practice. However, evidence taken throughout the country shows that there is such regional variation in both patterns of drug misuse and appropriate services to deal with them, that to insist on a rigid national policy would be inappropriate to the flexible approach shared between disciplines that

we feel is necessary.....(ACMD, 1982, p32)....We think it right therefore that even if there were to be central funding *the prime responsibility for responding to these problems should be at local rather than national level where the needs of both the potential clients and of those caring for them can be assessed* (1982: 37, emphasis added).

One interpretation may perceive this as a downward devolution of a morally problematic and socially unpopular group of predominantly poor patients. Indeed in one paragraph (10.5) the ACMD report (perhaps ambiguously) stated:

The statutory provision of specialist facilities for the treatment of drug misuse is now a matter for the local health and social services authorities. It is their *moral and social responsibility* to plan and develop services in the light of local needs and circumstances (ACMD, 1982: 76, emphasis added).

However, a more straightforward view would be to accept that the drug control issues were different from area to area and that this unassailable fact rendered a local configuration of policy more appropriate and effective. Thus whilst the committee would press for a certain kind of framework, at regional and district level, and make recommendations regarding certain specific questions, such as prescribing, the actual form of treatment would be left to a local amalgam to deliberate. Thus it seems, with regards to the formation and content of drug policy at this time, official national advisory recommendations accepted and even encouraged ground-up policy formulation for the treatment and rehabilitation of drug takers. The decisions on who provided help, of what type, intensity and duration, for whom and in what sharing out of resources, that is the constitution and expression of a 'policy', seems to have been broadly centred on a ground-up basis.

The report having recognised the geographical variation in drug problems, acknowledged in principle that no one treatment strategy could encompass effectively all the needs of drug users (1982: 31-32). However, the group was concerned with the question of prescription and the overall aim of treatment:

Throughout our discussion we have had in the forefront of our minds two major issues, first, whether it is right to prescribe controlled drugs to a misuser, and second whether the aim should always be to achieve a drug-free existence, or whether it is sufficient to enable a misuser to become stabilised (ACMD, 1982: 32).

While noting that previous reports, such as that of the second Brain committee, had accepted that even long term prescribing could be appropriate (1982: 33) the members voiced their doubts on this strategy:

There is increasing uncertainty as to the wisdom of a policy which has these effects [long term prescription] so that greater emphasis is now being placed on the ultimate objective of a drug free existence (ACMD, 1982: 33).

These reports seemingly send out messages that both recognise the present and future significance of the local site, but in certain cases, such as prescribing, attempt to stick to existing mentalities of truth and policies of abstinence. As we shall see in a later section in this chapter, this advice was roundly ignored by the GPs that actually treated drug using patients, once again highlighting that the 'prime responsibility' remained at the city level and could on occasion diverge from centralised advice. The Committees approach to the issue of prescribing may have reflected some of the findings of the group surrounding the attitude of health workers specifically in the psychiatric hospital (DDUs) services. Here they found centres that were inhibited by a demoralised staff in some way reminiscent of some of the experiences noted in the previous chapter:

With the change in the nature and extent of the problem there have been changes in attitude among some of those working in the hospital treatment services. It was apparent from evidence received on visits and in discussions that the policy of treating opioid misusers by prescribing long-term maintenance is now less commonly accepted.....Even less do they have the staff time or the physical facilities to respond to the newly emergent group of multiple drug misusers (ACMD, 1982: 27).

Two years later a DHSS report 'Guidelines of Good Clinical Practice in the Treatment of Drug Misuse'¹ (DHSS, 1984) noted both a reluctance among doctors and psychiatrists to provide NHS treatment to which patients were entitled and circumspection where maintenance was concerned (1984: 7).

Such reluctance is covered in a following section, but the ACMD did realise certain GPs would accept clinical responsibility. Further to this 'in the interests of both patient and society' the ACMD did not feel a total ban was justified (ACMD, 1982: 55) and indeed felt were this to happen it would result in drug control passing

exclusively to law enforcement (1982: 55). It is significant that once again the actual content of policy, what/when/how much to prescribe was left to the people on the ground. The realisation that hospital-based treatment was in relative decline, combined with the expertise and working methods of non-statutory agencies (1982: 84 recommendation 19) at improving responsibility for the individual provides an early national level recognition of the significance of the ground-up approach and the type of policies/practices evolving from it.

The next ACMD report (1984) focused primarily on prevention of use through education, much of the discussion being aimed at the non-user. Aside from the re-affirmation of the efforts of police and HM Customs (1984: 31) there was a strand of focus on reduction of social and medical harm for existing users. This call for research on 'harm reduction' signalled official recognition of a new type of treatment. General statements on prevention policy implicitly included those dealing with treatment of drug users and in their discussion of the type of organisational framework required, the council stated:

In the field of prevention of drug misuse we believe it is for the Government to determine an overall framework of policy within which other bodies at both national and local level can make an effective contribution. Other bodies can contribute to these tasks but prevention must on occasions be a political issue and therefore one on which ultimately the government of the day must take decisions (ACMD, 1984: 46).

This type of language stressed a slightly more statist or top-down approach. Certainly the importance of the local level was acknowledged, but in the last instance the central state responsibility was reasserted. However, the practical limitations of this can be interpreted from another section:

Equally there is need for co-ordination and for an improved flow of information between these levels. Policy trends must be communicated outwards from the centre; but if policy is to have a firm factual base, there must be a flow of information towards the centre on patterns of drug misuse and on trends in practice and the development of responses to drug misuse. One of the difficulties we have faced in our study has been to establish with any degree of certainty the extent to which local communities are responding to the problem of drug misuse and the measures they are adopting.....it is vital that new insights and initiatives should be developed in response to problems of drug misuse (ACMD, 1984: 46).

¹ Primarily concerned with providing tables of levels of drugs to be given in withdrawal management.

Whilst the Council used language reminiscent of Rock's analysis of policy measures emanating from the centre, the reality implicitly recognised was that trends and developments, constituting policy, remained rooted in 'local community' responses. Whilst vaguely described 'frameworks of policy' may develop at the national level new insights and initiatives, developed in response to geographical variation, would emanate from the ground-up.

Lastly a Home Office strategy publication (1986) provided a summary of government measures focused on a five point plan which involved reducing the importation of drugs through international co-operation and enforcement; hardening deterrence and policing domestically; developing prevention policies in training and education; and improving treatment and rehabilitation. By 1983 the Home Secretary had both restricted parole for drug traffickers to 5 years or more and further extended trafficking penalties from a maximum of 14 years to life (Controlled Drug (Penalties) Act 1985). These measures as well as an imposition of a fine upon imprisonment (unless deemed inappropriate) were extended to Scotland in 1985 under the Law Reform (Miscellaneous Provisions) (Scotland) Act 1985. With a workload estimated at being 70% drugs related, the Scottish Crime Squad had increased in size from 50 to 70 officers. The paper again reiterated the importance of the local site in policy when referring to the ACMD report of 1982 in that 'They accepted the Council's view that prime responsibility for the provision and development of services should remain at a local level' (Home Office, 1986: 22).

Importantly the Secretary of State for Social Services, in 1985, made over £17 million available for pump priming local drugs projects through what it called the Central Funding Initiative (CFI). By February 1986 £13.4 million had been allocated in England and Wales. The Scottish Office provided £1 million in 25 grants to similar local services with plans to provide a further £700, 000 in the year 1986/87. Of the 25 grants given in the first year 7 (£168,000 or 16.8% of Scottish total) went to Edinburgh groups 88% of the total money available being received by non-statutory organisations. The picture was different in Glasgow where 99% of the money awarded went through statutory services representing 32% of the whole whereas Aberdeen's distribution was mixed with 30% going to NGOs. Over 7 years (1983-1990), of the

total CFI budget of £17.5 million, and of 188 resulting grants, 42% were administered through the non-statutory sector, 56% through health authorities and the remainder through local authorities (Griffin, 1992: 47). Whilst all monies were locally administered the organisational landscape of drug policy changed significantly most notably in the largest growth area - that of the non-statutory agencies.

It has been argued that national-level committees consistently acknowledged the necessary significance of locally-formed policy solutions in the crucial period of increased heroin use between 1982-86. The next section, on locally-derived reports, not only reinforces the idea that agencies within Edinburgh were predominantly operating free of nationally or locally-imposed remits but importantly that they were doing so in newly emerging ways that can be characterised as being founded on techniques encouraging self-responsibility.

LOCAL AUTHORITY REPORTS: INITIATIVE AND INERTIA

During the early and mid-1980s there were three official reports compiled by local agencies in the Lothians. These reports were mainly concerned with a review of service provision. The first document, compiled by the Department of Planning in a report to the Policy and Resources Committee of Lothian Regional Council (LRC, 1983) presented a brief summary of current provision within the region including social work, education, health, police and voluntary organisations. The report noted that social work had 'no recognised priority or specific service for the treatment of drug abuse' (1983: para 24) relying on a generic approach covering need where encountered in their area. Again the report worried about the lack of a follow-up programme after detoxification following psychiatric treatment, noting in contrast that fledgling voluntary services offered just that approach designed to help change lifestyles and behaviour (1983: para 37). This early recognition of strategies aimed at transforming behaviour by making the individual more responsible for their use contrasted with the bleak picture of a lack of targeted and limited support from social work, GPs and psychiatry. It can be seen from the 1983 position statement that the evolution of voluntary services was crucial to bridging the gaps in the early local

statutory response in Edinburgh. The local position was evolving in an ad hoc pattern marked both by initiative and inertia on the ground, where it really mattered.

In July 1984 the Joint Working Party on Drugs Abuse (JWPDA), a corporate grouping of local authority, health board and police representatives, issued a progress report (JWPDA, 1984). There was little in the way of good news regarding any increase in the provision of local statutory services. It was also noted, as was an increasingly common feature in these reports, that psychiatrists were becoming ever more frustrated and resentful of the behaviour of patients leading in turn (as we will see in the next section) to a severe limitation on the role of the Royal Edinburgh Hospital in the ensuing drug problem (1984: paras 4.10-13). In contrast the paper noted that the Edinburgh Drug Abuse Action Group (EDAAG), an informal group of concerned professionals and voluntary workers, shared a belief in the need for the expansion of services that addressed the sustained motivation to come off drugs by offering an alternative 'lifestyle' (1984: paras 6.7-9). Hence the initiative, as perceived by local statutory authorities, in drugs policy (excluding law enforcement) was rapidly evolving along the lines of addressing the lifestyle and (self-) responsibility of the individual as opposed to their chemical detoxification, led in Edinburgh by a mixed group of statutory and non-statutory workers.

The JWPDA (1986) reported again two years later and looked at the functions and services provided in education information, training, professional services and their co-ordination. It was noted that the most recent initiatives were those of the voluntary agencies, through the community, as part of their attempt to normalise the drug problem. As the report stated this represented a somewhat untapped and novel approach reflective of their general flexibility: 'One of the strengths of these groups is that many of them are not confined or limited in their remit. There is a free-flowing creativity in all areas of work with drug users, their families, friends and with other agencies' (JWPDA, 1986: 4).

The development of lifestyle exploration and autonomy began to figure in proposals made for education and schools (1986: 5). Whilst there seemed no direct link between education and voluntary sectors there can be seen a perceptible drawing-together in

the techniques proposed as policy, forming a continuum of development of self-responsibility amongst teenage non-users and older users alike reflecting an innovative ground-up approach. Whilst the report noted the introduction by social work of a dedicated centre, as well as the expansion of Drugs Squad resources (1986: 12) this was offset by a general insufficient training of social workers throughout the department. Yet again the reported demise of psychiatric provision continued, with very poor attendance and abandonment of treatment (1986: 15). Whilst there was some concern over the monitoring of the effectiveness of these groups it was still admitted that ways of 'spreading this success more widely should be investigated' (1986: 32). Local initiatives that promoted alternative behaviour and greater self-responsibility through counselling and other encouragement were seen as the only way of involving drug users with agencies at the time (1986: 12). These methods were seen as the only effective 'policy' at the time, whether formally or informally made.

Reports at all levels recognised the significant change in patterns of drug use together with the inability of existing institutions and techniques such as detoxification to control rapidly expanding use. The agencies that grew to meet this challenge, Drugs Squad, voluntary organisations and a few GPs ushered in the emergence of new control strategies or the reconfiguration of old ones as we shall see later in this chapter. Griffin (1992) characterised the new strategies as a reformist model:

This [reformist] philosophy united doctors, social workers, those in statutory and those in non-statutory agencies. The model is concerned with rehabilitation and is based on social learning theories; it stresses the need for change in lifestyle if the aim of a drug free lifestyle is to be achieved (Griffin, 1992: 44).

The reports discussed above reflected centralised recognition of the existence and significance of local level drug policy formation. In addition the reports reflected both the retreat and demise of policy based on the chemical change of the individual's body with emphasis increasingly placed on longer lasting transformations. It was the concern with encouraging greater drug user self-responsibility that increasingly became the mainstay of policy response. Attention can now turn to the situated social practice of the agencies involved. In turn, analysis of agencies' responses develops the argument that it was at the expanding local level that policy was formed to meet the growth in heroin use and that it did so often in novel ways. However, as the first and

last sections (on psychiatry and the Drugs Squad) emphasise, policy within Edinburgh remained contested and far from unilinear.

Psychiatric Services: Withdrawal and Isolation (of Patients and Patience)

During the early and mid-1980s there was still only one psychiatrist who took responsibility for treating drug users at the Andrew Duncan Clinic. The consultant in charge had changed, but the resources directed into this field during these years had not. The provision of one half working day per week remained the extent of the commitment of psychiatry. From the late-seventies onwards there had been a hardening of attitude within psychiatry towards the treatment of drug users. This change was signalled with a re-emphasis of the policies of renunciation, described in the previous chapter, and of reduction. These changes can be perceived from the following extract taken from an interview with the consultant in charge during the early 1980s and shows both a greater concentration on purely psychiatric measures with a restriction on drugs prescribed to sedatives:

There was quite a surge due to the various problems on the international stage [Iran] and then drugs came into it. When I took over we devised a policy which really said that drug misusers would be assessed for their psychiatric problems, so they got a full psychiatric interview. Then they'd be seen several times for that. Attempts would be made to persuade them to come off the drugs. They may be helped giving a variety of treatments. I think [what] we were thinking of was perhaps to give them a sedative drug.

This move towards renunciation and abstinence inevitably led to a tightening of control over the manner in which the drugs prescribed were to be taken (whether they should be taken orally or should be injected), as the consultant reveals:

A. The policy we spelt out at the Royal Edinburgh is that we would prescribe only oral. We'd try and move down to the less dangerous drugs or the least potent rather.

Q. What happened to the people that were being given drugs under Dr. ***** when you started changing these policies?

A. They just got told.

Q. They just got told and that was that?

A. No more injectables. They were always on a balance, they were never just on injectables. They would have some oral and some injectables. You would just change the balance and cut out the injectables.

Despite the increase of intravenous drug use the Andrew Duncan Clinic was, noticeably, treating the same number of patients it had done in the time before this

upsurge in use. That this was the result of a change in the type of strategies used, a continued move towards reduction/renunciation, is indicated by the below extract from an interview with the same consultant:

I was quite limited in the amount of time I had. I rarely had nursing help, so you don't take all that many really. I think there would be about a dozen regulars and there were others who came and went. The numbers might go up to 15-20 and then down again. There were short term people who I gave three weeks detox in the community using methadone and other things, but there was a lot of contention about using methadone at all [in] the other consultants' general opinion. At that time there was the view that that didn't help the situation, it encouraged people to believe they didn't have to come off. The idea that the psychiatrist wanted was to send a definite message that when you come here you come off. The addict who came up had to be motivated to come off or had another [mental health] illness.

This renewed 'message' of renunciation, to the point where even short three week courses of substitution were questionable, can be seen as a reflection of a general 'professional resistance' to any move away from traditional 'Parsonian' concepts (discussed in the previous chapter) surrounding the 'sick'. This can be seen from the reflections of the consultant interviewed on those psychiatrists surrounding him:

People who are now senior doctors in the hospital would confront me and say you shouldn't be treating these people. They don't believe they should be anything to do with psychiatry. They had that belief, there are some people still in psychiatry [who believe], that unless they've got schizophrenia or depressive illness they wouldn't have them. If they've got that there's no question they get in, but they wouldn't have them for purely just drug misuse it's not their problem, that's a public health problem.

Unsurprisingly then this locally instigated policy of renewed renunciation brought with it the type of resistance to psychiatric policies from drug users highlighted in Chapter Two. This was accompanied by the tensions and disillusionment with this clientele, reminiscent of those that had affected this consultant's predecessor. The following passages taken from an interview with the acting consultant confirm this:

If I admitted them it was usually a disaster. We ended up with shouting and fighting. If I give them drugs that was great, but they came back purely to score.

They would always make themselves very obvious. They would wander in, they would arrive with two dogs, three girls and you're only seeing one of them. You were quite convinced they would perform the 'Madras Theory'. The 'Madras Theory' is what happened with tuberculosis. If one of the people of the family went to see the doctor in Madras and he'd got tuberculosis, he was actually given all the tablets he needed to treat his tuberculosis. However, he took them home and shared them with the family. I think there was a tendency to get one of them scored with you and then he shared them, he swapped them, so it was difficult to control.

Drug user resistances proved similar to ones highlighted in Chapter Two as inpatient admission proved a 'disaster'. Attempts to move from maintenance back to reduction met with familiar 'clipping' resistance described here as 'Madras Theory'. Decisions taken and policies determined at the local level could take a revisionist course. Such resistance combined with opposition within psychiatry and if anything an increase of frustration with users signalled a quiet disengagement, leaving psychiatric policy reluctant to adapt and moribund. This was at a time when local medical and voluntary services began experimentation with techniques of self-responsibilisation such as counselling. Importantly accompanying this practical policy evolution came a change, amongst some involved, in the way both the problem and its solution was conceptualised. These changing mentalities, as the next section argues, were locally derived from research and experience.

Community Medicine: Changing Discourses on Care and the Self

The numbers of drug users for which any medical practice became responsible varied enormously. The location of the practice would in many cases determine the amount of drug using patients. As has been previously noted, in areas where drug use was prevalent, medical groups found themselves receiving tens and even hundreds of such patients into their waiting rooms. For other surgeries the numbers were less and for many none at all.

Local GPs became aware of this escalating problem in areas that saw a rapid rise in use as one doctor describes:

Doing the ante-natal clinic you would get mums in who were covered with injection sites. You would get people coming in saying you know they wanted treatment for acne or something. You'd sort of say "Well take off your shirt" and you would say "What are all these?". They'd say "No no that's where I inject my heroin, the acne's up here". I mean they didn't want treatment for heroin addiction. It had just come into the area in a huge glut and you would say to people "Do you know any other heroin users?" and they'd say "Everybody I know".

Within general medical practice, as within psychiatry, there existed disagreement and doubts surrounding treatment of intravenous drug users. These arguments existed between surgeries and inside them. Those practitioners that were involved in treating

users describe some of the pressures that accompanied the willingness to provide treatment:

There were great internal problems in the practice because some of the partners disagreed wholeheartedly with what two or three of us were doing. You know it created tremendous stress within the practice which really in retrospect I regret, as well it didn't do us a lot of good, we lost a lot of patients. Our practice population changed, we just lost a whole group of middle class patients. I mean one of the partners had a lot of people in the New Town, doctors, teachers and lawyers, they all went. We became very much seen as a sort of bucket shop practice....and you know we had incidents in the waiting room where there was violence.

There were a number of GPs who were vehemently opposed to treating anybody with a drug problem. We said that they're entitled to a doctor first and foremost under the NHS rules and regulations. We felt that this was a load that should be shared across the board by GPs. In some ways it was an abrogation of responsibility not to take on even a small number because obviously it meant certain GPs were being overloaded if they showed the slightest interest or willingness to accept drug users on their list. ...Well there must have been a moral standpoint in some cases and others I think really felt threatened. Also one or two I think would have liked to have had a purely middle class style of practice and that this was rather messy and unquantifiable.

There was reluctance amongst many GPs to take on this work. Unwillingness stemmed from similar roots, as without a discernible cure, loss of middle class clientele, moral standpoints, time consuming patients, feeling threatened by those having a sickness and response seen as questionable, dispensing drugs was considered by many to promote the opposite of a cure.

However discourses within general practice that would increasingly undermine these resistances to treatment, were already starting. Research conducted by the Edinburgh Drug Addiction Study, housed within the West Granton Medical Group, critically evaluated the operating assumptions and services provided by the local psychiatric clinic. In their conclusions they did not, significantly, observe a difference in abstinence levels between those receiving treatment and those that did not. The explanation given by the authors for this lack of effectiveness was that:

Patients find the service both uncomfortable and inappropriate. The drug abusers studied showed little psychopathology and rarely saw themselves as suffering from psychiatric illness. Their inclusion in a general psychiatric clinic was reported to be a major reason for non-attendance (Bucknall, Robertson and Strachan, 1986: 999).

These findings suggested that both drug users' views and those of the physicians were in accordance with the majority of psychiatrists. These patients were not ill in the

accepted psychiatric view and such treatment lacked relevance. In addition the above further confirms both the drug user resistance and the form it took discussed in Chapter Two. A successful drug policy would have to include the participation of the drug user to ensure a minimising of resistance. Clearly the drug control problem had gone beyond the then existing techniques used at the Andrew Duncan Clinic. These findings on the rates of abstinence between treated and non-treated drug users had profound implications for future policy and technologies of control used. Not only did this approach undermine psychiatric treatment on the grounds of simple non-attendance but it also challenged the appropriateness of the central focus of such therapy, that of withdrawal to abstinence:

Episodes of abstinence occur spontaneously or as a result of social or personal circumstances indicates that drug use, like alcoholism, is a remitting and relapsing disorder. To suggest that someone is 'cured' after treatment is not therefore appropriate (Robertson, 1985: 35).

Instead energy was re-directed towards changing lifestyles and encouraging self-responsibility:

Therapy begins to share common characteristics familiar in health education...that is the task of helping individuals change harmful habits and develop new lifestyles...The drug user...makes an informed choice about his/her subsequent action. This combination of behavioural and cognitive strategies places the patient firmly in charge of the decision about changing his/her lifestyle and is obviously an approach that lends itself to self-help techniques (Ritson, 1986: 28-29).

This theory of secession from abstinence, by no means unique to Edinburgh, represents a change in the abstract ways of knowing about heroin control. This resonates with what, in a broader context, Rose sees as an 'intensification of subjectivity'. Rose argues that:

This embodies a shift away from emphasis upon morality – obedience to an externally imposed code of conduct and values in the name of the collective good – and towards ethics – the active and practical shaping by individuals of the daily practices of their own lives in the name of their own pleasures, contentments and fulfilments (Rose, 1999:178-179).

Abstract ways of knowing how to control drugs may be perceived as shifting from moral government – collective externally validated values – in the form of abstinence, to an ethical governance – techniques enabling active self-responsible conduct – in the technical use of technologies of the self. More broadly it can be questioned here

whether these abstract regimes of truth, discussed by Rose, can retain their discreet nature when analysed against this most pragmatic and grounded development.

The decision for change by doctors who did respond was influenced by changing beliefs in the value of treatment, organised around a conception of 'cure'. With this secession from a policy of renunciation in some local surgeries there emerged a new 'realistic' model of 'risk reduction' and emphasis on moving a 'chaotic drug taker in a productive direction' (Robertson, 1989: 378). This new medical 'relationship' with users when combined with a realisation of the potential benefits of voluntary organisation began the development of a multi-agency approach:

Voluntary agencies probably see and work with a large number of heroin users in the community who are not in contact with the medical establishment. The voluntary groups are therefore critical as an outlet for educational help and advice to the great many drug users who would not otherwise be reached (Robertson and Bucknall, 1986: 24).

Medical intervention strove for both the development of a more personal relationship with the user in order to effect transformation twinned with a recognition that 'on the ground' strategies were the only realistic approach to treatment:

Urgent decentralisation of treatment facilities and resources is necessary rather than formal, secondary referral agencies. Prescribing opiates is important but no one drug is of particular value. The main factor governing success is the closeness of the relationship between therapist and patient. That way a mutual responsibility develops, family and friends are drawn in and the worker develops a 'feel' for what is going on (Robertson, Skidmore and Roberts, 1988: 293).

This medical relationship between therapist and patient, with all its Foucauldian resonance regarding the relationships necessary for techniques of self-responsibilisation, in conjunction with voluntary organisations could accrue a knowledge/power relationship of great depth, as expressed by a doctor at the time:

Probably the single most useful ability that a general practitioner has is to observe an individual in his or her family and community context. This may allow an insight based on knowledge of previous generations of the drug user's family or of an accumulation of information from the involvement with this individual prior to, during or even beyond their drug using years (Robertson, 1989: 378).

Through this period a small number of practices expanded and experimented with a variety of substitute drugs such as methadone. By 1985 a newly marketed substitute Temgesic was used in one practice before being curtailed, as a GP explained:

In '85 we became aware of Temgesic, a painkilling drug. In '85 we started, which again is something I regret. There were some publications in the American journals of it being used as an adjunct to treatment and could reduce withdrawals and it was a mellower way of getting off drugs. So we started prescribing that. It became so popular that within the space of a few weeks we had a waiting room full of people. I remember it was just a riot. So we stopped one Monday morning, the waiting room was all full of people all banging on desks saying "I want Temgesics!". So we stopped, just cut it completely.

Later in 1985 the practice was prescribing some methadone for longer-term patients and "copious quantities of DF118" (dihydrocodeine, a mild analgesic). With risk reduction and prescription came a system of verification in order that patients' claims about their drug use or non-drug use could be more easily substantiated. The two principal techniques used for checking consumption of drugs were toxicological analysis of urine and the examination of the body for injection sites and pinpoint pupils. Random urine testing by practitioners, dealing with drug users in Edinburgh, began in the early 1980s. There were two types of test available, usually only one of which was used per sample. The first of these was the commercially available Boehringer Mannheim Opiate E.M. test. This was a simple and quickly used mixture in a vial, which recorded the presence or absence of opiates in a sample. The second test was a more complex one called the TLC Kit System (Toxi-Lab), which had the capability to screen for a wider variety of drugs. This kit was made available through the Department of Clinical Chemistry at the University of Edinburgh. The advantages of using such methods of screening are revealed in the following extract from an article written by Edinburgh medical practitioners and academics:

Screening facilities have an additional advantage in stabilising the doctor-patient relationship. The presence of this facility, even when only used intermittently, makes the patient realise that any deception may be detected. The failure to produce a sample for analysis was often interpreted by the doctor as an indication that it was likely to be positive and the increased care taken by persistent drug users to attend appointments in a non-intoxicated state leads to additional improvements in managing problem drug users in the general practice setting (Skidmore, Robertson, Simpson and Jarvie, 1987: 397).

Toxicological analysis, importing techniques designed to increase drug user self-responsibility, could provide a variety of knowledge about the drug user. It could be

used to confirm or contradict patients' declaration of being drug free. Using the second more detailed technique a check could be run on whether the drugs being taken by the drug user, who was in receipt of prescribed drugs, matched those that showed up on the screening. This technique reduced the risk of the drug user supplementing their intake and also attempted to reduce the resale of such goods on the drugs market. More generally such testing, when it was used, could give a limited snap-shot of the local consumption of drugs, as Skidmore et al. indicated: 'The presence of a number of other substances in the patient's urine, demonstrated by the non-opiate drug results, is a useful indication of which drugs are locally available' (Skidmore et al. 1987: 397).

A second technique of verification was 'the regular checking of the body for injection sites, a technique which became common practice for some doctors. Arms and later the whole body, might be checked as one doctor recounted: 'You get discolouration, scabbing and if they had sites that had obviously been used at some point where the vessel was thrombosed you could feel it by palpation. You would then start looking in other sites, however bizarre'.

Drug policy within general practice in Edinburgh, it is argued, was not formed by abstract or centralised deliberations but built predominantly on the local experience and research with which GPs were confronted daily. In addition new techniques of observed substitution attracted drugs users into regular contact, reduced risks and attempted to transform behaviour through verified choices of drug lifestyle and the self-monitoring of drug intake it encouraged. The GP-user relationship became a major factor both in intervention and changing the nature of drug policy in a similar direction to voluntary organisations.

Before we examine the policies of the emerging voluntary organisations, a brief exposition of the policies of the Lothian Social Work Department's only dedicated drugs project will follow. This will provide yet another instance where local ground up decision making significantly changed the remit away from abstinence only service provision.

Social Work in the Community: Changing the Remit

Lothian Social Work Department dealt with a number of drug users indirectly through, for example, work done with people released from prison. However, there remained throughout this period little provision of specialist services for drug users initiated by the local authority agency. As one worker said of those times:

In fairness the individual social workers were doing a lot with drugs, but the Department at the time wasn't really. Most of the work at that particular time was being done by the independent [voluntary] sector.....I think we got involved in it because of the type of folk that were getting involved in drugs, rather than because it was a problem we thought we could set out to do something about.

The earliest specific response to heroin use from social work, which gained impetus from a few local residents' requests for help, was the drugs project set up in the Muirhouse area social work office in 1984. The project funded two staff, a social worker and a clinical psychologist and saw a comparatively small number of users, around twenty at any one time. The reasons for such low numbers remain unclear but there may have been a reluctance to visit social work for these problems particularly on the part of females with children, or there may have been 'competition' from nearby agencies. The project also refused to do work with under 16s as it was concerned with issues such as labelling, and pejorative and glamorising effects. Project staff also provided a rolling programme of in-house training and information for social workers on the reasons, consequences and responses to drug use. The initial remit for the provision of this counselling service is described in an interview extract provided by one of the project workers: "The remit ...was to provide an individual counselling service for heroin users. The expectation...at that point would have been that we were working to get folk off. Success was going to be measured in terms of how many referrals we had and how many of those referrals attained abstinence".

However, the workers at the project challenged this very stark categorisation of success and its finite aim: "It's very clear you're either on or off. 'It's worked if you're off it's not if you're still on'... We didn't agree with this and this was accepted, [it] took a lot of discussion but it was accepted". Success was not to be measured solely in terms of how many remained abstinent, but by such things as lengthening the periods

of being off heroin. The counselling and contact with drug users was thus more open-ended as described in the interview extract below:

So we were prepared to have folk come in for whatever, they just had to have something they wanted to talk about in relation to their drug use. They may not want to stop. They might want to think about stopping. They may just want to blether about the good bits and bad bits of using drugs, anything was fine. Anything that would get folk through the door and start a relationship going. Hopefully some time they were making a decision that they might try and stop.

This altered remit signalled a change in local authority policy. This change was at a practical level rather than one officially adopted though, as the interviewed worker reveals in the following passage:

No one would have publicly said that that's what they were funding us to do, or the Department was allowing us to do, although in fact that's what they were all doing.

Again an evolution in policy, albeit initially unofficial, can be seen to have been generated from the ground upwards. Through pragmatic relationships established it was hoped users would be encouraged to decide themselves to change, reminiscent of Foucault's technologies of the self. The next two sections complete an analysis of the significance of the local level (outside law enforcement). The focus here is on the rise of the voluntary organisations in drug policy. Many of the participants in this evolving 'third sector' came from a background of 'community involvement'. The responses of these agencies reflected a pragmatic approach focused on local rather than national networks of power. Additionally it was these agencies, in tandem with local GPs, which did most to foster the emergence of new techniques that encouraged self-responsibility.

The Voluntary Drugs Agencies: Self-Responsibilization in the Community

It will be argued in the following sections that the services offered by the voluntary agencies represent both an expansion in policies derived from the ground-up and proved significant instigators of new emergent strategies characterised as techniques of self-responsibilisation. It is this pattern of services, their origins and evolution during the first half of the 1980s that will now be examined.

Much of the early involvement and organisation of these agencies was undertaken by people who described themselves as 'local activists'. These were often non-professionals involved in other local committees or working in community-based projects, such as youth projects for the unemployed, in the late 1970s and early 1980s. It was often through such local projects that the increasing use of heroin in the early 1980s became known to these workers, as one interviewed volunteer working at a drop-in centre for young people related:

We saw that some of the young people were involved in, or were certainly talking about, various forms of drugs e.g. alcohol, amphetamines, cannabis and increasingly heroin. They were mainly 15-16 year olds. I began to pull together a group of people in the community who were concerned about drugs.

Similarly, people working in another community organisation, again a youth programme, recognised this problem. They began to form services out of existing agencies, as the next interview extract with a voluntary worker explains:

I was involved with an unemployed group for both males and females in the area. It was very obvious to me that things were nae quite right. Young people were coming in and obviously had drug problems. I decided to split [the service] and open up two nights a week to allow the people who were using drugs [to come in] and it became a regular thing.

Gradually more volunteers became drawn into this community level response. Some became involved through their own experience of drug use, some because they were parents of drug users. Others had been doing different community work and became interested in drug agencies as the following interviewee explains:

I became involved in a lot of different activities...Then I got accosted, basically, by the two workers in the [drugs] project. ...They asked me if I'd like to come along and serve on the committee. I didn't know a thing about drugs, but I had quite a lot of committee experience. Then I became a volunteer because I wanted to take a more active interest. So I went through the volunteer training course and I became a volunteer.

Another feature of these agencies was the participation of families in the initiation of these projects. Families in areas heavily affected by drug use, sometimes with drug users in their own families, in many cases started the petition for services in the community. One worker interviewed, briefly describes the actions and concerns of families in one area as follows:

They were people that just went to the Rep [Representative] Council saying 'Hang on, we've got to do something here'. They were mainly concerned parents who, one or two of them, realised or suspected that their children were involved in drug use. As I said they wanted to do something positive about it instead of going to the police.

One observer's view at the time was that these families were very much the dynamic force behind the community level response, saying that: 'Families were involved in appointing staff, they were involved in providing the service, in supporting others. You know they were the focus of activity around which drug users' needs were met'.

Whether it was family, friends, community workers or drug users themselves, the impetus for many of these agencies seems to have been determinedly from the ground up within the locality rather than parachuted in from above. In a relatively small city local networks were quickly established, often amongst people who already knew each other, forming loose associations such as ELDAG (Edinburgh/Lothian Drug action Group formerly EDAAG) where 'everybody knew everybody' as they all went back a long time, meeting in pubs such as the *Cask and Barrel* in Broughton Street.

The increased involvement of the volunteer organisations and their staff during the 1980s and 1990s can be contrasted with the often reluctant involvement of the welfare professionals. Garland's depiction (2000; 2001) of professional middle class abandonment of welfare strategies and dwindling importance of their social expertise can be perceived, at least within Edinburgh, in psychiatry's disengagement, social work's peripheral role and the majority of GPs lengthy resistance to engaging with drug users. Management of marginalised drug users during this period in Edinburgh was taken on by the willed activism of locally evolved groups. These groups did not however espouse the professionalised expert approach that Garland characterised the welfare professionals as having (2001: 149). This voluntary/statutory 'third sector' according to Garland forms the 'most significant development in the crime control field... the new apparatus of prevention and security' (2001: 148). Whilst local groups in Edinburgh might not fit neatly under such an umbrella they do closely resemble another characterisation of that sector as exerting 'a small but insistent pressure that tends to push policy away from retribution, deterrence and reform and towards a concern with prevention, harm reduction and risk management' (2001: 149). Garland goes little further in his assessment of this sector. As will be argued next, the

importance these local groups had in fostering the introduction of new techniques of drug control in Edinburgh cannot be underestimated.

Activism in the Community: Affirmative Counselling and Self-Responsibility or 'Breaking the Good Time Guy'

Community-level responses recognised that the subject's drug abuse was often connected with and exacerbated by other existing problems, such as unemployment and poor housing. Voluntary agencies, whilst realising that they could not create jobs and change other social conditions *per se*, attempted to help, as one agency worker relates, in the following ways:

So I think the kind of tack that we took was you work on the other problems first, ... maybe try and get somebody stabilised. Once you get a stable person you can start to work on the other problems... You do what is called networking, you go over to other organisations and get yourself known... *I mean there are a lot of things you can't improve. You can improve a person, but you can't improve their surroundings.* We couldnae improve the housing we tried to get people along [emphasis added].

In order to support the growing numbers of drug users and address this problem at a community level, a collection of techniques were improvised, including, drop-in centres offering support and advice, public meetings, home visit appointments and outreach work. In addition public meetings were called where the local residents and others connected with drug issues were invited to attend to gauge what the feeling was around the area. One agency, WEST (West Edinburgh Support Team), opted not to provide a drop-in facility. Instead they decided to instigate a home visiting service. One worker from this project explained the reasoning behind this:

We prefer to meet people in a place of their own choice, that could be their home. We thought we don't want to have a drop-in service because that could be very chaotic. The best way to handle that is to maybe meet them in their own environment... which kind of served a dual purpose. You got to see the person, but you also got to see the environment they lived in which a lot of the times is one of the problems. [There is] Probably despair at the time, you know...a lot of times they turn to drugs to help them forget it or block it out.

The basic technique used by these community organisations was that of counselling. The methods used to get in touch with people, as we have seen, differed. The help given because of its personal nature also varied. However, the standard tool used in

providing help was that of talking with the person, without a link to the provision of prescribed drugs. One worker at the time attempted to formulate the meaning of counselling:

Counselling being a really loose word, you really just have to give the person an opportunity to talk. They will be talking to a non-judgemental person, which again is probably for the first time in their life... everywhere they went it was a door slammed in their face, because they were a junkie. So you basically listen to them and through that and your own counselling skills, you bring out what the main problems are... and then work on them one at a time.

Counselling according to this view, is a process of change based on a relationship of trust aimed at reflection which leads to a gradual transformation in behaviour. As such it may be said to aim to break down the moral attitudes to drug use/users to which this marginalised group had previously been exposed. One ex-user latterly came to work in one of the non-statutory agencies. The then user was offered counselling, support and advice on a weekly basis, and his recollection of this assistance highlights how these relationships of self-responsibility were built and change nurtured. The counselling helped with self-esteem and life review where the user:

Could see points in my life where I did fuck up...it [counselling] tries to motivate you to look at your own behaviour...why you did it. It was simple in my case we're just breaking the good time guy in me I suppose. Looking at the responsibilities that you have.

This provides confirmation, from one ex-user, that within counselling a technique for the management of the self was deployed. The client was guided, through a relationship of trust between confessor and 'therapist', to become focused on constituting a new more responsible self. Lifestyle changed in a number of ways for the heroin user. With a prescription for maintenance drugs the user stayed off the streets more: 'I lived like a hermit for the first six months....I just couldn't face people coming up to me asking do you want to buy this'. Being known to be on a counselling programme also made other users more wary of the ex-user: 'People who I associated with in the streets...I certainly found it a lot harder to find them'. This isolation from other users and their very active lifestyle reinforced the feeling of separateness from and a little ignorance of the drug scene on the streets: 'Yer felt like when I did decide to start going out that I felt like I'd lost it. Even with a couple of weeks away from the street things change, different dealers'. This is not just a reflection ('pondering,

thinking, what am I going to do. I've got some responsibilities here') that shifts the user's perspective but the whole environment changes around them. The meaning of their surroundings changes when the very active lifestyle where they were always up to something is replaced by pondering on their responsibilities and 'breaking the good time guy'. It is these types of relationships, with advisors, and the behavioural change that provide a resonance with Foucault's techniques of self-responsibilisation.

In addition to appointed home visits and drop-in centres, another more proactive method was used by one of the agencies, WEST, that of providing an outreach service. Outreach represented an attempt to engage drug users in the community to contact the agency as well as make the service better known to the drug users in the area. The (rather unspecified) nature of this work is related by one of the workers who undertook outreach work in West Edinburgh at the time:

A. We still actually toil to say what we mean by outreach work. Our main outreach work is going to the shopping centre, because that's still the main place for people to hang about, especially in winter time. So basically you just go into the shopping centre, you don't really approach people and they get to know you very quickly.

Q. How, if you don't approach them, do they get to know you?

A. Being a local person. I had a lot of respect from a lot of people. People could identify the project with ****. I do a lot of things locally. It's just about getting yourself known. Asking what people are up to, talk to them and from that I think you reap the benefits...if even one person might think, somewhere along the line they might phone up and say look I've got a wee drug problem could you help me. We've found outreach difficult to be honest.

One former worker at W.E.S.T. gave another, more definitive, explanation of outreach work:

Q. ..That must have been a tough thing to try? To try and normalise with people getting their tellies nicked. How did you actually do that, did you have meetings?

A. Yeah, I think there was I suppose two sides to a community there was the people who were affected by it and there was the people who were anti to it. But...why ostracise these folk [drug users] as they are part of the community. And also some of the education work we were doing with youth workers or the community groups, the women's groups so I think that again came from the bottom up we were trying to do things to normalise...in terms of like de-marginalising or de-stigmatising.

In practical terms this meant getting others in the community to look at their own experiences:

A. We'd do women's groups maybe the church maybe social work..

Q. So what happened when you turned up at a women's group what would you say?

A. We didn't focus on the drugs we actually focused on them as women and some of the issues with kids and things like that so it was a fairly community approach. We would do stuff on drugs education we would do looking at attitudes looking at stereotypes and attitudes...look at their own dependency.

Common to all these agencies was a certain acceptance of drug use. This acceptance of drug use was coextensive with the techniques applied to the drugs problem, such as non-judgemental counselling. This certain acceptance of drug use and self-responsibility was aimed at achieving greater mutual understanding between the agency, drug-using clients and the wider community. Agencies attempted to destigmatise, or normalise, this problem in order that contacts could be facilitated, maintained, and offered support. This seemingly loosely formulated idea was explained in the following way by an interviewed project worker:

I think to get the community to realise that it [drug use] is part and parcel of life nowadays. It's not things that happen in wee dingy dens or something like that. It's a normal thing of life, unfortunately. Drug use is very widespread and it was people wanting to be up front about it, we didn't want to hide the fact. The community thinks that we own the problem. We don't own the problem, the problem belongs to everybody. We are responsible to a certain degree over certain things, but the problem belongs to everybody else, we can't 'clean up drugs'.

Again these broader community activities represent an attempt to deconstruct fixed perceptions of drug use and users. This attempt to 'educate' the drug user and surrounding residents often met with hostility from the many people who had become victims of drug related crime. One community worker explained:

It's really hard to get people to accept things when they may be the victims, when somebody breaks into their house and steals their tv and video. It all depends what way people have been affected by it. If they're affected by it because maybe one of their sons or daughters or husband or whatever is using drugs, or they could be affected because they've been mugged on the street or could have broken into their house. Their response was dependent on how they're affected.

Over time this collection of initiatives came to be known under a variety of aliases such as: 'harm reduction', 'harm minimisation', 'risk reduction' or 'risk minimisation'. Strategies used by voluntary organisations signalled a more positive understanding of the need for longer-term reduction and building of self-responsibility. Some workers also perceived that it was not the drugs that were the problem, but the abuse of the drug and the wider reasons for this as one agency member reflected:

The drug is no' the problem. It's the abuse of the drug and why is it being abused? It's being abused because you got fuck all else to do. Get yourself a set of scales, you've got a fiver, fiver bit ae smack? Couple of pints in a local pub? Away home with a sare heid or blitzed dreaming nice dreams.

The aim of counselling was not just to stop drug use, rather it was more to deal with a variety of problems and so stabilise the user's life so they were in a position to make lifestyle changes later. As such these services represented a clear manifestation of what Foucault described as technologies of the self. Intervention sought to enable the user to reassert themselves over their diverse problems. 'The self' became the issue not the drugs. Added to this some of the agencies sought to address the community and their moral conceptions of drug users. They attempted to normalise, de-mythologise, the issue of drugs by embedding an awareness of the normalcy of drug use, not as a moral question, but as 'part and parcel of life nowadays' as a 'normal thing of life'. However, much of this endeavour to de-stigmatise lacked form and progress, the strongest resistance coming from victims of drug related crime. With attempts at normalisation comes an ambiguous discourse. If these drugs are normal, a part of life and society, this would partially undermine and question their prohibition. It does not contradict attempts to curtail abuse of these drugs or the dangers people may encounter taking them, just as in the case of alcohol. Rather it implicitly questions the need for their prohibition and punishment, which neither cures nor prevents, as against strategies of regulation and harm minimisation.

It is argued that these newly emerging ways of dealing with heroin use were formed at the street level. Although many of the groups had some funding from The Scottish Office, monitoring was highly infrequent and of little importance (or constraint), being described by one worker as 'it was two wee guys...they came around and they were fairly inoffensive'. With little centralised monitoring the autonomy of agencies working at this period and level was quite pronounced as one voluntary worker summed up:

In terms of being accountable I think they [Scottish Home and Health Department] were giving everybody quite a free range at the time...because they were completely ignorant so it was steered by the community - do you know what I mean - it was steered by that it came bottom up.

It must be remembered that these later technologies emerged within wider power relations. Even though the technique of renunciation, as we have seen earlier, was seemingly on the wane, the other existing technology of control, prohibition and criminalisation, was expanding. In the next section attention will be focused on the policy of the drug squad and the increase in criminalisation of intravenous drug use during this period. Once again this continued criminalisation proves a reminder that local level policy was very much contested in nature.

The Drugs Squad: Increasing the Criminalisation of i.v. Drug Users

The Drugs Squad also became aware of a massive increase in injected heroin use. There was additionally a growing perception that there existed a correlation between growing numbers of users and the amount of drug-related crime committed. To confirm these worrying suspicions an in house survey of regional police statistics was undertaken at the behest of the Chief Inspector of the Drugs Squad. The following extract taken from an interview with a then serving Drugs Squad officer indicates the results of this survey:

What was becoming obvious to the cops was the amount of heroin they were finding, the amount of junkies they were coming across, was just going through the roof. They saw a direct correlation between crime being committed and the amount of heroin abuse. So they did their own survey. Basically what they did they got the crime statistics for a given period of time. You had X amount of crimes reported against that you had Y number of crimes detected. Where persons had been detected they checked the names against the cards of our criminal intelligence cards, that were in the old Drugs Squad. They said how many of these folk do we actually know are using hard drugs. When they did the survey it came out that over 40% of the solved crime was being done by those who were using hard drugs...probably to get money to buy drugs, they decided that it was about time that somebody else was recognising that this was a major problem and it was highlighted to the Chief Constable.

This seems to be the same survey referred to in the 1983 Report of the Chief Constable. Even though the statistics between the oral and written accounts vary it would seem likely that the below extract is talking about the same survey:

In an effort to gauge the extent of the relationship between crime and drugs abuse, a survey was carried out over the first 6 months of 1983 to determine how many persons reported or arrested for the crime of theft by housebreaking within Edinburgh, were known to be 'hard' drug abusers. While the survey was not conducted in such a way as to provide conclusive results, it was revealing to find that an average of 34.5% of all such persons had links with drug abuse (Lothian and Borders Police, 1983: 48).

One of the immediate effects of this survey was an increase in Drugs Squad resources, gaining a sergeant and four acting officers. This increase allowed a change in squad tactics. Previously most work was done on information received and 'crashing doors down'. Now a greater emphasis could be placed with longer-term surveillance on dealers and suppliers using target teams. What this survey also reinforced was the increased criminalisation of the drugs problem. Drug users had previously been perceived, by the police, as involved in illicit use of drugs and breaking into premises to obtain such drugs. Users, as the extracts above and below reveal, were now becoming heavily associated with a broader range of crime, such as housebreaking, shoplifting and credit card fraud, to obtain money to buy drugs with. This criminal 'mainstreaming' reinforced the vision that this was a purely law enforcement problem. Drug users were being pursued not only by the Drugs Squad, but by other police sections involved in policing more general thefts. Cheque and credit card fraud rose dramatically during this period and was seen as being heavily linked to drug use, as the testimony of the Cheque and Credit Card Squad indicated that:

[There were] 2,804 offences resulting in 2,030 cases. The largest proportion of offences involving stolen cheques and credit cards are still the result of thefts which have taken place in the Edinburgh area and normally these items are still used locally at banks and shops by local criminals, quite often from the drug fraternity (Lothian and Borders Police, 1983: 46).

Additional recognition of this changing state of the drugs problem was provided by the increasing numbers of the traditional criminal milieu becoming involved in the supply and dealing side of drugs. Fears of increasing criminal organisation in the distribution of drugs in the early 1980s was highlighted by one serving officer:

A. It was starting to get quite frightening. You were getting people who hadn't been involved in drugs in any way, they were out-and-out criminals. This is the sort of element that you were now starting to deal with. They had connections throughout the country and this was the way it was going.

Q. So drugs were becoming more organised?

A. Very much so and a lot of the names you were coming into contact with through your informants were the sort of respected criminal of the previous year, the ones who seemed to do the big jobs but never got caught. Now they were transferring over to drugs and some of the targets we were taking on were hard going.

Both through the increasing 'street crime' of individual drug users and the involvement of better connected criminals in the organisation and sale of drugs, the

local heroin scene had become firmly connected to mainstream crime. The problem of intravenous drug use was now perceived, by law enforcement, as having a direct impact on the total amount of 'petty theft'. The police also saw the problem as being vertically integrated as an organised crime involving large sums of money and an increasing level of violence. In this way the drugs problem had extended into the general crime problem. Money now was becoming more important in the drugs market, rather than just the exchange of drugs. This wealth was generated locally, largely on the basis of a great many small sales of ten and twenty pound bags. The increased levels of violence were not directed towards the police, but within the drugs market itself, taking the form of anything from small rip-offs to warring between rivals.

Drugs Squad strategy was aimed at punitive solutions at all levels. They saw the drugs problem as an interconnected criminally motivated and organised whole. In order to stop drug use, action had to be targeted at each and all levels. One serving officer at the time, in the below interview extract, conceives this strategy in symbolic terms:

I sort of likened it and I still do, to if you walked into Safeway and your looking at the proverbial pyramid pile of tins of beans. Your top tin of beans was like your top dealer. Its easy to take the top tin of beans out but its so easy to replace it. My theory was a reverse pyramid effect. If you can start to take dealers out at different levels, they might be top men, they might be small men at the bottom end. The one who gets a gram of smack and then has decided well he needs a quarter gram but he's gonna supply the remainder and the remainder will pay for his habit, he's still a dealer. By taking dealers out at different levels, the equivalent to cans at different levels in the pyramid, the pyramid becomes less and less secure and eventually collapses. That was happening, the supply of drugs, particularly smack, did drop drastically because people were becoming very, very frightened of the severe sentences.

The principle of targeting 'Mr Big' then never existed. In order to stop the trade and use of drugs, policing had to be aimed at all levels to bring the now more structured drug scene to the point of collapse. There was little or no room in this theory for discriminating between a user and a dealer. All were seen as involved at some level in the dealing of drugs, an opinion further confirmed in the extract below by another officer. Additionally the small drug dealer of the present might progress to selling larger amounts in the future as the following interview extract, with an officer active in the 1980s, alludes to:

I see these statements in the press saying we're getting the wrong people. Any ladder in the world, you don't climb it by jumping on the fourth or fifth rung [up]. You've really got to start from the bottom rungs to get to the fourth or fifth rungs and that's the way I view it.

Because all drug users increasingly came to be perceived as being involved in the supply of drugs, the charges made out against them often reflected this as one Drugs Squad officer at the time confirms:

It wasn't just possession. There was always a supply charge there, either intent to supply, concerned in the supply of, there was always a supply charge there of some description.

In 1985, a year often associated with declining intravenous drug use in Edinburgh, there were officially 146 charges for possession of heroin as against 169 related to its supply (Lothian and Borders Police, 1985: 22). The research and concern generated by the Drugs Squad, further criminalising perceptions and approaches, through 'up-tariffing' reflected the local autonomy of the unit in terms of organisation and policy. Mike Collison (1995) saw this autonomy within the force as endemic:

For it is clear that the hierarchical...model of enforcement organisation accords with neither the structure of the drug market nor the day-to-day realities of drug work. In this situation detectives make it up as they go along - and they teach it to new recruits. Drug enforcement becomes a DIY enterprise with relatively little strategic and intelligence co-ordination. (Collison, 1995: 132)

Through the esoteric nature of approaches to drugs enforcement the Squad attained and maintained a level of autonomy to set policy agendas on drugs policing where, as Collison stated, 'enforcement meaningfully takes place - the street' (1995: 12). The local potency of this autonomy and its effects on law enforcement policy are apparent throughout the periods discussed from informal agreements obtained with the courts in the previous chapter to the increased numbers imprisoned for longer sentences shown below. The local site of enforcement, the streets, became increasingly important, especially for those at its mercy, the users, and other agencies with different policy agendas. Sally Haw and Jason Ditton, looking at drug policies in Scotland generally, commented on how the law on the books was being applied on the streets:

What has characterised the Scottish response has been an increasingly literal interpretation of the 'supply offences' contained within the Misuse of Drugs regulations. And so, the "intent to supply it to another" in Section 5 (3) of the 1971 Act was often inferred (by judges and juries) from quantity alone, in the absence of financial records, scales and means of packaging. As a

consequence, a drug user in possession of more than one or two days' supply, put himself in danger of being held to have intent. At the same time, drug users were convicted under Section 4 (3) (a) of the Act (to supply a controlled drug) when the evidence indicated that they had only shared drugs with a friend. Finally, "to be concerned in the supplying" of a controlled drug (Section 4 (3) (b) might be inferred, if directions were given to another indicating where drugs might be purchased. These interpretations of the Misuse of Drugs Act Regulations brought many drug users within the operational definitions of 'drug dealing' employed by the police and Crown (Haw and Ditton, 1995: 14)

With a harsher interpretation of supply related activity came a rise in the numbers of drug users going to the High Court. Haw and Ditton reflected on the increasing percentage of drug prosecutions that formed part of the High Court workload, together with the accompanying harsher penalties. They found that:

In 1980 less than 1% of High Court criminal prosecutions involved drug offences but by 1986 the proportion had reached 27%. Mean sentence lengths for convicted drug offenders rose dramatically from 321 days in 1981 to a peak of 1,132 days in 1984 and then fell gradually in the following years to 712 in 1987. To some extent both the increasing drug workload in the High Court and the increase in mean sentences for convicted drug offenders reflected an increase in the seriousness of offences committed. However, Scottish judges who were interviewed in connection with the study indicated that many of those convicted of trafficking offences at this time were drug users who sold drugs to finance their habits. In spite of this, severe exemplary sentences were imposed and a prison sentence of 4 years might be expected by a drug user who was supplying small quantities of opiate drugs (Haw and Ditton, 1995: 14)

This type of tariff was confirmed by the words of a serving Drugs Squad officer at the time:

The minimum that you could expect in those days was 4 years. If you got 4 years they were going out the court laughing, having been found guilty or pled guilty.

Stephen Woolman in an albeit limited survey of cases, came to the following conclusions:

Offences involving the supply or importation of heroin cause little difficulty in the manner of disposal. In both England and Scotland imprisonment is regarded as the only proper course for the courts to adopt. The actual 'going rate' for such sentences would, however, appear to be different. Lord Lane indicated that in England "a sentence of less than three years would seldom be justified, and the nearer the source of supply the defendant was shown to be, the heavier would be the sentence. In Scotland, on the other hand, six years imprisonment appears to be the normal sentence for anyone convicted of possession with intent to supply, irrespective of whether the value of the drugs involved is £1,600 (30th April) or £50,000 (2nd April) (Woolman, 1985: 107).

The length of sentences being handed down in the High Court at this time is confirmed by the Report of the Chief Constable 1984:

During 1984, 41 dealers appeared on indictment at both High Court and Sheriff Court in Edinburgh and were sentenced to a total of 173 years. Of these 26 persons appeared at court in the last three months and received 126 years all told (Lothian and Borders Police, 1984: 29).

The average sentence at this time ranged between 4-6 years. Woolman, like Haw and Ditton, also noted that the people being convicted and given these increased sentences were rarely the major 'players' but instead were quite often small time dealers:

Where the Mr. Bigs are caught the maximum penalties can be utilised. Unfortunately this happens all too rarely and it is those lower down the distribution chain who are usually brought before the courts (Woolman, 1985: 107)

This pattern of catching mostly 'little fish' in the law enforcement dragnet persisted and was still being noted in Collison's study conducted in 1990:

Staying with quantitative measurement the distribution of seizures can give some (although always imperfect) insight into the kind of successful operations underpinning the...aggregate figures. Fifty-three per cent of heroin seizures by the police involved quantities of less than one gram [sic] and a further 22 per cent were recorded as of unknown quantity (i.e. likely to be of the 'trace' variety on paraphernalia; tin foil, spoons, knives, wraps, syringes and so on). That is, 75 per cent of heroin seizures were of quantities more typical of the user or petty dealer end of the market (Collison, 1995: 198)

As can be seen from the above, discourses of prohibition established a mutual relationship between drug abuse and an 'extra'-criminal dimension. The police survey, referred to at the beginning of this section, helped to confirm and objectify drug users in a similar manner to Foucault's description of the relationship of power and the individual:

The individual, that is, is not the *vis-à-vis* of power; it is, I believe, one of its prime effects. The individual is an effect of power, and at the same time, or precisely to the extent to which it is that effect, it is the element of its articulation. The individual which power has constituted is at the same time its vehicle (Gordon, 1980: 98).

The drug-using individual is at once a result or consequence of this power of prohibition and a part of its utterance. Questions of statistical analysis aside, this survey (discussed at the start of this section) like others of its type, effected the drug user as the criminalised individual. Precisely to this extent the drug user became part of a growing researched discourse typically involving an evaluation concerning

causation (Hammersley et al. 1990). Traditional mentalities were further reinforced where power fixed on all those involved in a perceived inter-linked organisation of heroin use. The way users were articulated in power relations also had effects for arrest and punishment.

Within these power relations there can be seen the possibility of contradiction and conflict. This conflict was most apparent in relations between the Drugs Squad and the voluntary organisations. Drawing on the themes of criminalisation and technologies of self-responsibility we can now briefly examine the relations between these agencies.

Powerful Competition: Self-Responsibilization versus Prohibition

In this context of competing concepts and practical initiatives surrounding drug use some signs of strains between certain agencies developed. Despite some interviewees professing to have had good relations with one another, perhaps the greatest strain was felt between the Drugs Squad and voluntary organisations, as is revealed in police reservations about the staff, as one officer related:

You see we saw these people as having information that they should have been passing to us. They saw themselves as having to have the trust of the people they were dealing with. Don't forget a lot of these voluntary groups that suddenly sprung up in the heroin problem were convicted addicts who got grants from the system to keep their habits going and they do that under the disguise of being health agencies. So therefore we were at war with them. That's not quite it, it wasn't open warfare, but we didn't trust them and they didn't trust us, they had their own view. A lot of these people were unskilled, untutored, redundant addicts and it then became difficult to differentiate between the people who had a genuine desire to help and the people who were just working the system. We just ignored them and they just ignored us.

Collison also reflected on this gulf where police officers saw voluntary workers as condoning drug crime whilst such workers perceived the Drugs Squad to be following a different, punitive, agenda (see Collison, 1995: 109).

In addition the consultant psychiatrist at the time complained of the poor relationship between the clinic and one of the community organisations:

They were negative to professionals like us, yes. There is always a tension and they felt themselves very much on the side of the drug misuser.

Social workers perceived their relations with the police as being good but this was in contrast to the perceived friction noted between some of the voluntary agencies and the police:

I think when some of the voluntaries were set up there was a degree of suspicion about what might be going on in these projects and I think some of them had to negotiate with the police, that they wouldn't go in the premises and that kind of thing.

Only once was there a recalled incident of police interference at the social work site:

Once the police followed a guy in and asked to search his bags. The minute I came down and I came down quite quickly, they shot off because they should not have been searching anyone in our waiting room. Wait outside for him but don't come inside.

Voluntary agencies and Drugs Squad both had an interest in drugs and drug users but, as one voluntary worker relates, they saw that their angles of approach diverged:

The problems started because you used to get from the police 'We're in the same game as you'. We're not, they want to get arrests to make themselves look good, whereas we're trying to help people with drug use.

Certain agencies attempted to bridge this gap by trying to come to some understanding with the Drugs Squad. In the interview extract below an agency worker describes one route of dialogue tried and the problems they felt were encountered:

[We were] Talking about trying to get understanding with policemen. We do inputs at what they call refresher courses. You sit there and you've got about 20-odd police officers and you know fine you can be talking away and you look at them. They look at you as if to say what the hell are you talking about. Then they challenge you right, then hopefully from that you can maybe break down some of the barriers, but it doesn't happen at the end of the day.

These new techniques of self-responsibility aimed at regulating harm clashed with those structured around the prohibition of use. These policies did not so much cancel one another out, as continue in a wary coexistence. This diversity in policy, and any resistance, can be understood in terms of what Foucault called a 'polyvalence of discourses':

We must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies (Foucault, 1979a: 100).

Foucault however, suggests that there is nothing strange in this multiplicity; it is to be expected. He perceives discourse, here policy, as 'discontinuous segments' whose functioning he characterises as 'neither uniform nor stable'. Thus far from a search for the cohesive universal policy, it is the variants and different effects that signify a more complex and unstable process. It is this sense of the discontinuous and contingent, that gives a clearer reflection of policy. These 'discontinuous segments' of policy remained contested and to a certain degree intensified during this period.

Perceptions of the drug user also diversified. Some agencies attempted a certain degree of normalisation of the problem in their work and communities. Such an approach can be loosely related to Garland's depiction of a 'criminology of the self' that characterises offenders as rational consumers just like us (Garland, 1996: 461). Other agencies, notably the Drugs Squad, and certainly some members (vigilantes or not) of the communities most affected perceived the user as the threatening outcast, the excluded, forming a 'criminology of the other' (1996: 461). Agencies that deployed technologies of the self perceived and depicted the drug user problem as one of enabled self-responsibilisation. These agencies concentrated changing subjectivities whilst different agencies, of 'the other', focused on objectification. Dichotomous articulations of the individual and the problem both developed and intensified from within the local context.

This chapter has argued that the expansion in heroin use was met with further local ground-up development in policy rather than one developed from the top down. Importantly drug policy was not only formed at the ground level but was recognised as being such by central ACMD reports. As the local psychiatric department instigated its own withdrawal and isolation from service provision so a locally constituted amalgam of GPs and voluntary organisations tried to fill the void. This third sector relied on their local experience and research to introduce new ways of looking at the problem. This combined with the emergence of pragmatic techniques of self-responsibility. Similarly it was local practice that continued to dominate law

enforcement perception and practice of criminalisation based, like GPs, on their own internally generated research, experience and concerns.

Analysis in the following chapter will chart the expansion and adaptation of these technologies of the self, together with policies of prohibition, in a new period of drug policy, from the mid-1980s to the early 1990s, distinguished by the unique and tragic factor of HIV/AIDS. This deadly new epidemic was far from unique to Edinburgh but certainly affected the city more than most in the UK. Again it will be argued that the reaction to this change was very much at the ground level.

CHAPTER 4

CHANGING PRIORITIES: HIV, intravenous drug use and Technologies of a 'Safer Self'.

The previous two chapters have argued that drug control policy in Edinburgh from the 1970s to the mid-1980s was significantly influenced at the local level. This chapter reinforces this argument by analysing the importance of local-level reaction to HIV infection within the Edinburgh intravenous drug using community. First, it is argued, that the local identification of the dangers of the spread of HIV and the development of strategies of control changed the focus of drug control in Edinburgh. The findings of exceptionally high rates of HIV infection among Edinburgh's drug users combined with warnings of the potential threat of a spread of the virus to the wider heterosexual community, led to calls for greater availability of clean needles and prompted an exemplary policy response. The Edinburgh situation and response became incorporated into a wider Scottish approach, manifested in the findings and recommendations of the McClelland Report (1986). HIV in Scotland, in the 1980s, predominantly affected drug users, which was not the case south of the border, making the Scottish experience distinct within the UK. The epicentre of high Scottish infection rates was Edinburgh, making the response of agencies' focus on drug use rather than sexuality. This new dynamic informed wider debate on the control of drugs in the UK.

The emergent strategies of self-responsibilisation, discussed in the last chapter, assumed increasing significance in this new policy dilemma of HIV/AIDS. Policies that were being developed to control drug use were now re-deployed in a development of the techniques of the self into one of a 'safer self'. The second argument in this chapter is that the development of policies of a safer self represent a radiated evolution and 'strategic elaboration', in the Foucauldian sense (Foucault, 1980b: 195), of the deployment of technologies of self-responsibilisation to control the threat of intravenous-spread HIV. Foucault points to this process of strategic elaboration regarding imprisonment. For Foucault the constitution of a delinquent milieu that the prison effected was re-utilised as a process for filtering and professionalising a

criminal class (1980b: 195-196). Within Edinburgh the techniques of the safer self were re-utilised and adapted from techniques of self-responsibilisation (described in the last chapter) to respond to the urgent need of HIV prevention. Techniques of safer self-responsibilisation are, from the mid-1980s onwards, primarily directed at the management of shared injecting use rather than the deviance of drug use. HIV prevention did not rely solely on needle provision. As will be argued later in this chapter non-injectable substitute drugs were prescribed not just to attract users to services but also to divert them from injection. Intervention attempted to change not only the way a drug was used but the drug that was taken.

The realisation of the dangers of HIV increasingly drew medical professionals and institutions into discourses and policies surrounding heroin injection. This increased involvement could be characterised as a medicalisation or re-medicalisation of drug policy. However such a characterisation has certain limitations. Broom and Woodward (1996: 361) distinguish the term 'medicalisation', the expansion of the scope and social relevance of medicine, from instances of 'medical dominance' in, for example, the conduct of consultations and medical opinions in policy making. For Zola medicine as an institution socially controls through a number of mechanisms. These include medical rhetoric, exclusive access, and priority in treating the body and mind allowing its designation as a 'medical problem' or 'illness' (1972: 495). However, as we have already seen in the preceding chapters and will see again in this one, medical institutions are often divided in their rhetoric, involvement and definition of a problem as medical or an illness. Additionally, medicine does not have exclusivity or even priority over the access to the body of a drug user, particularly where law enforcement or needle confiscation is concerned. Part of the problem of this definition is that whilst it may provide a useful term signalling increased medical involvement, intervention or participation, it assumes prior knowledge of where the boundaries between what is medical and what is not are located. Equally it assumes that medical control is discrete in nature. Such limitations are apparent in Szasz's notion of 'pharmacracy' as a distinct rule (Szasz, 1975: 139) which limits the amount of interplay and seepage from and to other sites where control is deployed. This type of analysis essentially illuminates only the 'who' it is who supposedly has power, rather than the question of 'how' these interventions are applied and how (as Foucault

contends) power is 'invested in its real and effective practices'. This is the case even when Zola and other writers such as Lowenburg and Davis (1994) discuss 'how' medical practice works. Whilst Zola's description of the change toward preventive medicine (Zola, 1972: 493) and Lowenburg and Davis' discussion of the move to holistic health (Lowenburg and Davis, 1994: 581) provide language resonant with technologies of the self, they both share a certain control-blindness. Such analysis assumes an 'inherent democratic value' (1994: 581) in certain practice changes but ignores the possibility of the more subtle mechanisms of social control that operate on the individual subjectivity and the ways in which the 'self' is constituted.

It was during the mid-1980s that needle sharing among intravenous drug users first became an important factor associated with heroin use in Edinburgh and other Scottish cities such as Dundee and Glasgow. This practice was more limited south of the border (McClelland, 1986: 4). A brief description of needle sharing in Edinburgh before the advent of HIV/AIDS will provide a background to the important changes in intravenous drug policies that evolved as a result of the growing implications of HIV.

SHARING 'WORKS' A BRIEF DESCRIPTION ____

The sharing of 'works' (needle and syringe) depended principally on their availability. In the late 1960s/early 1970s supply of needles came mainly through the same route as the supply of drugs, namely through chemist shop break-ins. This could be supplemented by a ruse of presenting as a diabetic, sometimes with an obtained diabetic identity card, in need of injecting equipment. The ease of obtaining this equipment was aided by the fact that at this time there were relatively few users and hence little awareness of the problem or the fact that supply might be for such a use. Such ease evaporated in the late 1970s with the target-hardening of certain chemist shops and all but disappeared with the growing realisation of the intravenous drugs problem in 1980s' Edinburgh. The supply of injecting equipment was briefly restored through one particular surgical supply shop in Bread Street, but this was soon curtailed due to pressure from a variety of sources. The importance of the cessation of

supply from these sources should not be underestimated¹. Robertson (1990) in his study of the spread of HIV in Edinburgh during the 1980s has this to say regarding the closure of the said shop:

The last surviving enthusiastic retail supplier was forced out of business in late 1982 and the self-reported incidence of dangerous needle-sharing escalated further. In his final year of business this pharmaceutical supplier reports selling needles and syringes to a large number of individuals who he knew injected; at times he sold boxes of 100 to people who supplied the market. ...Through this time police activity included an informal policy of trying to cut out the availability of any needles and syringes and in this way reduce the extent of injectable drug use. Although well intentioned, this practice may have encouraged sharing of injecting equipment to become the norm amongst users (Robertson, 1990: 97).

This position is reinforced by the recollections of a former drug user interviewed on video in 1989 by Dr. Judy Greenwood who kindly allowed a viewing. The ex-user recalled the shop and that the owner was quite happy to sell over the counter. Regarding the closure of the shop and its effects he went on to say:

I don't know if it was commercial pressure or pressure from the police/DS. That was when in my opinion when everything got out of hand. Because [afterwards] I can remember using needles/syringes 6-8 months after that [closure] that were literally held together with bits of thread round the rubber bit. Whereas before you could get the whole set for 18pence.

JG Did you find yourself sharing with other people?

Yes as the drug scene became more dangerous it would become more common to use in the place where I bought the stuff.

JG When you say more dangerous what do you mean?

When pressure from the DS became more intense.

The reasons for the closure and resultant level of infection will perhaps remain impossible to assess without testimony from the proprietor. However as preceding extracts, and later disclosures from Drug Squad officers, indicate the rather 'wholesale' distribution of needles this shop was engaged in would have completely contradicted the pressure being applied by law enforcement regarding the confiscation of needles.

For some it was still possible to secure their own supply of works. The difficulty in obtaining needles is reflected by the more elaborate and sometimes desperate

¹It has been impossible to trace the person who ran this shop, as they left the area many years before the present research commenced and did not keep in touch with anyone known to the researcher. None of the Drug Squad members interviewed could remember this shop or were assigned elsewhere.

techniques of obtaining supplies discussed below. One ex-drug user used his appearance to effect a diabetic ruse by wearing a suit and polishing his accent:

I could go into a chemist with a suit on..and even talk a wee bit more articulately ..your own personal appearance and your articulate way of asking that sort of played a bit ae a part in whether you could get them [works] out of a chemists. Dinnae get me wrong I've been knocked back suited up as well. It's not as if every time I went in a suit it was a success. You knew which chemists you could go to. A hard-bitten chemist in Muirhouse you just wouldn't go to. You would sneak off to somewhere like Morningside or Colinton where they would feel afraid of offending you.

This tactic was obviously not available to many. A supply could still be secured, through exchange, if the user was also dealing. Increasingly the only route of supply, for many, was through opportunistic stealing on the occasion of being admitted to a hospital service such as Accident and Emergency. Another hospital service where a limited supply of needles could be obtained was at the City Hospital, Regional Infectious Diseases Unit. This unit treated drug users who had infections, such as hepatitis. Needles used in infection treatment although disposed of in a secure box provided insufficient deterrence, as one worker in the Unit relates;

I remember a sister came to me about how the hell do we stop people stealing the needled syringes...we had this lock shop you put them in. The problem was people were putting their hands in and taking them back out again.

One ex-user related the 'everyday' process of sharing works when users came to buy drugs in their home:

They sat down in my house...You could see them willing you to say, 'by the way if you want to do it here',.... if you didnae do it they'd ask anyway...and [that was] virtually 9 out of 10 people that were in the house scoring... rather than having to drive away back or get a bus back. So [they would say] 'Is it awright if I use here' 'Aye sure everybody else does' 'Borrow them'. You're talking about works that were perfectly clean and just in case you were no satisfied you'd still like go to the sink and wash them. That is where the sharing needles came in. I would say that 90% of people that came away with 'I've left the works in the house' didnae have any anyway. They just couldnae get them.

The practice of lending works was part of the routine in 'shooting galleries'. These sites were designed to be resistant to police raids with a fast turnover of people to go in, pay for and receive an injection of heroin. One Drugs Squad officer at the time describes these places in the context of his observations on how they were set up and problems involved in capture:

They came about because they would select a house they would deal from...Pay your cash and it was all over in two or three minutes. You'd get a dozen folk at the door they would make their £10 packets and there would be works there. They would shoot up unless we got into the house in that 3 minutes. They just had to hold a piece of paper up and go phhh [ignite it], and we had no case. We took hundreds of search warrants out and a lot of them were negative.

Sharing and Hepatitis B, pre-HIV

By sharing works, the drug user ran an increased risk of a variety of infections. Possibly the most serious of these infections was that of the Hepatitis B virus (HBV). Hepatitis B is transmitted via the same routes as HIV, though hepatitis is more infectious (Strang and Farrell, 1991). Infection can develop in a number of ways and can be divided into acute and chronic phases. Acute hepatitis may result in fatigue, appetite/weight loss or no symptoms at all. Alternatively the infected person may become ill with jaundice. In both cases the virus may either clear, or develop into chronic hepatitis. In a very small minority of cases, those ill with jaundice, may develop 'fulminant' hepatitis which has an 80% mortality rate. Persons with chronic hepatitis may not show any signs of disease. People may carry the virus for years without further development; others however, may develop severe liver problems such as cirrhosis of the liver. The Regional Infectious Diseases Unit, at the City Hospital, dealt with people infected with hepatitis. In the 1970s one of the larger groups presenting with such infections were drug users, as a consultant working there confirms: 'For the ten years in the seventies the commonest reason to come in here with Hepatitis B would be drug use or because they're gay'.

Officers working in the Drugs Squad throughout these years were well aware of such infection amongst drug users:

We spent a lot of time in personal contact with these folk hanging on to their throat to stop them swallowing stuff. We were jabbed by needles and had to go up and have hepatitis jabs. We all have, it's not just me.

This problem was viewed as so serious that senior Scottish and Police Federation representatives were given specialist briefings in London (Smith, 1986: 360) followed in 1986 with the Lothian and Borders force being the first to offer a limited voluntary immunisation for 66 'at risk' employees (Police Review, 1986: 1437). Increased awareness may have been partially responsible for a practice of needle retention on

public health grounds that with hindsight may have done little to prevent sharing, but at the time was hoped to promote clean needle use as recalled by one officer:

When the infections started coming up we got all sorts of lectures on guarding ourselves so you tended to just, if you weren't using them as evidence, throw them all in a bag and take them away and then in a sort of scary way you thought you were doing your bit for public health, forcing them into getting clean works.

In an agency with so much experience and intervention in drug subculture such a hope could be said to be naïve at best. Against this background hepatitis infection rates rapidly increased, peaking in 1984. Recorded cases notified to the Community Health Services were followed up by Environmental Health Officers who attempted infection tracing through case contact. Amid increasing inability to make case contact, data analysed from 1979-84 showed a rise from 12 (1979) to 63 (1984) confirmed drug-related cases, with the number of cases increasing by 33 in 1983-84 alone (Haw and Liddell, 1986). Based upon reports of hepatitis testing labs, figures (referring to Lothian rather than Edinburgh) produced by the Scottish Centre for Infection and Environmental Health confirm these trends with a rise from just over 100 (1983) to just under 200 (1984) between 1983-84 (SCIEH, 1996). In 1985 confirmed notifications of viral hepatitis morbidity were likewise almost three times (907 as compared to 352) what they had been in 1980 (Scottish Health Statistics 1995). These statistics can be matched by observations amongst health practitioners at the time. One GP working in an area associated with high rates of drug use remembered how they first noticed the high incidence of hepatitis: 'When this surgery was being built...the people working on the site, the unskilled labour force, were all local kids and they were all injecting heroin and they all came over to see me and they all had hepatitis'.

The underlying importance of this epidemic was that it was indicative of increased needle sharing and that it was connected with a more deadly infection as the doctor went on to say: 'They all wanted sick lines...I said you'll be fine in a couple of days and they were fine in a couple of days. They recovered, but they got HIV at that time...That was the HIV epidemic and that's when they got it'.

By the mid-'80s a situation had developed where needle-sharing and increasing hepatitis infection remained largely ignored with an absence of targeted services and

unabated confiscation of needles. In the next few years knowledge of the level of infection began to materialise through the research of a small local group of medical personnel caring for drug users.

THE FIRST DESCRIPTIONS OF HIV

It was publications by medical staff within Edinburgh who were involved in drug issues and virology that provided initial descriptions of HIV within the UK. Initial concern fell on the high rates of measured HIV infection (38% among serum samples) in one of the earliest published articles (Peutherer et al. 1985). These alarming statistics were confirmed when even worse sero positive rates of 51% were recorded among drug users attending an Edinburgh general practice (Robertson et al. 1986a). This was well above drug user rates elsewhere in the UK and comparable to those in New York (Robertson, 1986a). Hart (1989), looking at the data on the geographical distribution of tested blood provided by the Communicable Disease Surveillance Centre (CDSC) in 1987 provides the following summary that highlights the relatively high Scottish HIV rates within the UK and the distinct drug-related nature of infection:

By September 1987, whereas most cases of AIDS (75 per cent) came from the four Thames health regions, and only 3 per cent from Scotland, of the total number of HIV positive persons, 54% were to be found in the Thames region and 18 per cent in Scotland. When expressed in terms of rates per 100,000 total population however, the Thames region remains the worst affected by HIV infection with a figure of thirty per 100,000 but Scotland follows closely (at twenty-six per 100,000): the majority of Scottish cases have injecting drug use as their primary risk factor (Hart, 1989: 162).

As will be seen in later sections, the majority of Scottish cases were located in Edinburgh. Scotland (and the capital in particular) had a problem distinct from the rest of the UK in terms of infection route and group. Explanation of these rates, compared to Glasgow, centred on the number of occasions needles were shared, rather than amount of people sharing (Robertson, 1986). This situation, compounded by Drugs Squad needle confiscation led to speculation that even higher rates could be expected (Robertson, 1986a: 527). Further local research and researchers focused attention on the infection/needle-sharing dynamic (Brettley et al., 1986a; Brettley, 1986b; Brettley et al., 1987). Additionally these researchers began raising points such as a call for wider

needle availability: 'Sterile needles and syringes should be provided, on a new for old basis, to reduce needle sharing amongst IVDAs [Intravenous drug abusers]' (Brett et al., 1986a: 1099).

Secondly there was an implied fear/warning expressed in the fact that drug users were by and large heterosexual: 'This...should re-emphasise the fact that if this disease becomes disseminated into the general population it will do so from heterosexual parenteral drug abusers' (Brett et al., 1987: 423). Of additional initial importance were the findings in a study of a New York cohort of drug users (Des Jarlais, 1987). The researchers concluded that continued drug injection may cause increased HIV related immunosuppression. The effect that these findings had on policy related to drug use is evident in the changing emphasis in the reports generated in Lothian and Scotland during the years 1986-87. The primary focus of the reports, described below, changed from a concentration on services provided for drug users to reports that considered drug use in the context of HIV infection. The recommendations closely resembled the points being made by Edinburgh researchers and practitioners.

HIV AND A CHANGE OF OFFICIAL EMPHASIS

The focus of 'Drugs Action Lothian' (JWPDA, 1986) was to 'identify relevant resource functions and agencies responsible for positive action' (LRC 1986) and make recommendations on health education, training, services and research. Whilst concern was expressed over HIV and needle-sharing little in the way of firm action was formulated, recognising both calls for greater equipment availability and worries about the lack of effectiveness and increased use this may have (LRC, 1986: 32-33). By publication the report was seemingly obsolete.

One month prior to the issue of this report the Scottish Committee on HIV infection and Intravenous Drug Misuse met for the first time in response to these initial studies (McClelland, 1986: 1). The committee chaired by Dr. McClelland² included five members, of the committee of thirteen, who were medical personnel based in Edinburgh. Of these five, a community medicine specialist, a GP and a member of

² Director of South East Scotland Regional Blood Transfusion Service.

EDAG shared voluntary sector approaches on self-responsibilisation, and provided much of the indigenous literature relied upon, and helped form the majority approach of the committee. The McClelland committee brought together people that were already doing something on the ground rather than drawing on members from the central Scottish Office. The committee, reporting in September 1986, recognised both that the Scottish HIV experience was distinct in the UK and that infection was a greater threat to individual life than drug misuse (1986: 4). Additionally, with drug users being heterosexually active with non-drug users, and some turning to prostitution to fund their use, stopping the spread of HIV beyond marginalised groups further prioritised virus containment:

There is therefore a serious risk that infected drug misusers will spread HIV beyond the presently recognised high risk groups and into the sexually active general population....The gravity of the problem is such that on balance the containment of the spread of the virus is a higher priority in management than the prevention of drug misuse (1986: 5).

The committee found that of the 795 HIV positive cases reported in Scotland, up to June 1986, 511 (64%) were from identified injecting drug users (1986: 5). Of the total 482 known HIV positive people in Edinburgh, representing 60.6% of Scottish cases, 351 (72.8%) were classed as intravenous drug users (1986: 17). This concentration amongst Edinburgh's drug using population indicated a very different situation to the 54 (2.6%) infected injecting drug users from 2,081 cases south of the border (1986: 6). With levels of tested infection in England and Wales no higher than 11%, committee members attempted to explain this situation with reference to several important factors:

First, in Edinburgh the emphasis of police activity has been on discouraging the sale of syringes and needles, and removing these items from individuals found in the possession of them. The resultant non-availability of sterile equipment in the city, appears to have contributed to extensive sharing of equipment. Second, there has been a prevailing medical opposition to maintenance prescribing, and a generally low level of investment in provision of a medical drug-dependency service which may have led many drug users to sever contacts with hospital clinics or other medical agencies, or to avoid seeking professional assistance (1986: 7).

This statement represented the public manifestation of conflict between competing convictions surrounding the future management of intravenous drug misusers. The committee condemned the lack of GP and psychiatric involvement and conversely the intensity of Drugs Squad intervention. By contrast the committee made favourable

mention of policies in Amsterdam observing the high levels of contact between user and agency, that would be required for effective action (1986: 8). The committee felt two main conditions were required for effective action. First, was the provision of substitute drug prescribing to attract drug users to services and lessen the amount of injecting. Secondly it was recognised that some users, even if given substitutes, would not stop injecting but should be provided with sterile equipment (1986: 9). Drawing on evidence from Amsterdam showing little indications of injury to the general public from discarded needles (and New York showing behaviour change in acquiring/use of sterile equipment) counter-arguments of encouraging use and needle-stick injuries were over-ruled (1986: 10). It concluded distribution of equipment should be given only where advice, 'medical if necessary', was available in tandem with guidance on safe injection and safe sex. To ensure that this was treated seriously as part of their actual recommendations the Committee stated that: 'Police policies in relation to individual drug misusers should be reviewed to ensure so far as possible that they do not prejudice the infection control measures recommended' (1986: 14).

The key words contained in the five main recommendations were those of; *reduction* of use generally, *persuasion* to stop injecting, *persuasion* to inject safely, *provision* of encouragement and support to stop use or prolong remission from use and *education* of users concerning the variety of health risks surrounding HIV (1986: 9). The similarities between and continuum of policies already existent and sourced from a local level site within Edinburgh were echoed in the recommended Scottish national approach of harm minimisation and self-responsibility: 'All drug misusers must be brought into contact with sources of the necessary advice and practical support, and must be motivated to take effective personal action...The services must be seen by the misusers as offering support and assistance rather than having the sole objective of stopping drug misuse....'(1986: 9).

Established approaches to injecting drug use combined with the particular circumstances of injection and infection in Edinburgh and Scotland ensured the city level provided the key codes of policy formation carried to the national level by the McClelland Committee. The 'Edinburgh experience' continued to influence policy deliberations at a more general level when in March 1987, at a seminar in the Queen

Elisabeth Centre, London, the attending delegates, including the Chief Medical Officer of England and Wales (Sir Donald Acheson) heard directly from Dr. Brian McClelland. The message conveyed to this policy community reinforced the concerns and approaches of the McClelland report that the Edinburgh experience of HIV infection was a warning beacon of what could happen to cities further south (McClelland, 1987: 81-82). All UK cities with a drugs problem became a potential 'Edinburgh'. This was further recognised by the visit to Edinburgh of the high profile Social Services Committee in 1987. They took evidence from a number of different agencies connected with HIV issues. Notable by its absence was any request for attendance from the Royal Edinburgh Psychiatry Department. Those called to give evidence were keen to stress the particular Scottish dimension to the HIV problem and the opinion that this peculiarity would not last, as Mr Roger Kent (Director of Social Work) among others provided in his evidence given on the 12th March 1987: 'What we are trying to emphasise is that it is not exclusively about homosexual behaviour. We have a very real problem that I do not doubt at all will occur elsewhere in the UK later on. It just happens that we have got it first' (House of Commons Social Services Committee, 1987: 211 para 827).

This notion was confirmed in the final report of the committee when they explained the reason for their visit to the capital. 'We visited Edinburgh because it is believed that the experience of the Lothian Region may be the model for other areas with drug abusing populations' (House of Commons Social Services Committee, 1987: pxxxii). This was reinforced by evidence provided by Dr. George Bath the Community Medicine Specialist when he earnestly speculated: 'We are currently not really seeing the Scottish epidemic; we are seeing a shadow of the English epidemic. When our epidemic comes along, any time now, it will be predominantly one of intravenous drug abusers' (House of Commons, 1987: 183, para 684).

The report directly acknowledged the impact of the McClelland report as being the spur towards the establishment of the first needle exchanges in the UK: 'The Government, in response to the recommendation of the McClelland Report, has set up pilot schemes for needle exchanges to last six months in nine cities throughout the country, including Edinburgh, Glasgow and Dundee' (House of Commons, 1987:

xxxiii). In assessing the impact of the adopted approach of the McClelland Committee Berridge (1996), whilst having noted the time it took for central political legitimisation of these policies, stressed the importance of the Scottish dynamic effect in UK HIV/drug policy: 'It was to take much longer for needle exchange and harm minimization to receive official political legitimation. In policy terms, it was the McClelland committee which pioneered that line in relation to AIDS; the Scottish dimension to policy was significant' (Berridge, 1996: 96).

In November 1986 The Scottish Office Minister for Health and Social Work, Lord Glenarthur, set up a working party to advise on services for patients infected with AIDS, reporting its findings, as the Tayler Report, in 1987. Although interest in drugs policy was indirect, the approach taken reflected and reiterated McClelland. The greatest projected increase was again within the drug using community suggesting that the 'potential for heterosexual transmission is probably greater in Lothian than anywhere else in the UK' (Richardson and Gaskell, 1989: 71). The working party reiterated the message that the future direction of policy was as follows: 'In the case of sexual transmission or drug abuse, the ultimate means of controlling spread, in the absence of a therapeutic option such as a vaccine, is behaviour modification. This depends heavily on the motivation of the infected individual to adopt a 'socially responsible' attitude' (Tayler, 1987: 37-38).

Further to this, the report recommended that patients should be treated as normally as possible, in the community and collaboratively between all local agencies (1987: 59). Thus as Berridge points out, local level community care became a model adopted at national level: 'For AIDS, as in the case of the changes in drug policy, this was an impetus which came initially from Scotland....This was a message which meshed with the policy response in the rest of Britain' (Berridge, 1996: 168).

These reports were important for a number of reasons. First, they highlighted how experience at the city level had played a significant part in defining the nature of a fast-evolving problem in drug use and HIV. Both the contemporary and projected extent and route of transmission was based on local research findings. The problem had been proselytised from the bottom up, from the city, through Scottish committees

- loaded with Edinburgh representatives - to UK level representatives. The policy response was based upon pre-existing techniques of self-responsibilising behaviour generated from the ground-up. Techniques of self-responsibility became inscribed in national UK drug policy through the wider elaboration and implementation of maintenance and counselling packaged as harm minimisation in the context and from the impetus of the cities most affected. Contained in this argument is an underlying criticism of the way such local influence and formation of policy has been rather underplayed by such studies as Berridge's (1996). For whilst Berridge's highly detailed account of the history of HIV/AIDS does chronicle 'policy from below' between 1981-85, thereafter local policy development becomes characterised by Berridge as marginal to a more centralist state interpretation. The book accurately represents the UK HIV problem as being initially one involving risk activities surrounding individual sexuality. However, as we have seen, this tends to conceal important differences in the experience between Scotland and England. This rather Anglo-centric reading of policy formation only occasionally refers to Scottish experience when it directly impacts on deliberations south of the border. The focus remains on sexuality rather than the more fragmented reality that existed in UK policy during this time. The tendency then is to obscure the distinct Scottish problem of drug user infection within an analysis based on sexuality and a homogenised 'UK policy'. Berridge's general approach tends to render latent the more subtle inspection of policy formation and its older and more local roots.

The policy recommendations and applications that followed, can be seen as manifestations of a strategic elaboration of already existing technologies of the self. Technologies of a 'safer self', utilised to prevent infection from HIV, referred to the same autonomy and self-responsibilisation processes discussed previously with regards to harm reducing drug use. In both cases behavioural modification expressly relied upon individual adoption of a 'socially responsible' attitude. The 'stepped support' of equipment and substitute drug provision, were predicated on a concentration of 'support and advise' to motivate 'effective personal action' (McClelland, 1986: 9) heavily reminiscent of previous voluntary approaches. Techniques of the self-based policies through journal papers, reports and practice on the ground begin to acquire a pre-eminence at a local level and founded important

shifts in national policy. Whilst the war on drugs did not cease more care is taken with the prisoners. Pressure became mounted on agencies whose practices are perceived to conflict with infection prevention especially the Drugs Squad practice of confiscating needles/syringes. Techniques previously utilised at the local level continued to be influential in HIV prevention through a number of different units now analysed including the Regional Infectious Diseases Unit, needle exchanges and the Community Drug Problem Service.

THE STRATEGIC ELABORATION OF INTRAVENOUS DRUG USE

The work of the Regional Infectious Diseases Unit: Public Health and Maintenance

HIV prevention within the drug using community led to an increase in service provision from some medical units. The Regional Infectious Diseases Unit (RIDU), at the City Hospital, had previously dealt with drug users when they became infected with Hepatitis B. Their work with drug users was to change in character and extent due to the threat to the stored blood supplies of the health authorities, before comprehensive screening of all blood products arrived, as one consultant at the RIDU relates:

What was decided [in October 1985] was that if you want to protect the blood supply you don't want people popping down to donate a pint of blood to find out if they are positive. So effectively you offer testing to keep people away from the blood supply...Not surprisingly nobody wanted to look after the drug users so I said well we'll do it because we've looked after them before. It was decided that if you were a drug user you go to The City Hospital....We then had to set something up to attract drug users.

To protect the blood supply methadone was used to attract and screen drug users. One further reason given for prescribing methadone as the same consultant recalled was:

The reason I took it on [methadone prescribing] was Don Des Jarlais in June of '86 presented a paper in Paris in which he showed a direct relationship between frequency in injecting and crashing CD4 counts. So for the first time we had evidence, nobody has been able to repeat that work, that said if you carry on injecting you'll go faster.

Additionally there was the feeling that if prescription and treatment of infection was to be given then it should be done in one place:

I'm not saying that if we didn't prescribe drugs they wouldn't come but for many people it's a major factor...anyone else when they have tried two centres, an HIV centre and a drugs centre, it doesn't work. I don't believe it is all methadone I believe that methadone is important as a first link to get people in.

There were some medical staff who had misgivings about prescribing methadone that revealed traditional reservations about the handling of drug users and conflict over policy priorities. Once again local level pragmatism prevailed:

The guidelines said don't give a prescription for more than 14 days which I slightly ignored. I said I was managing very much like a public health measure. I just said there's an epidemic and we've got to stop them injecting. There were lots of attempts administratively to stop that. I started [prescribing methadone] in '86 it must have been mid '87 I ran out of [prescription] pads, we had these special pink pads. In three months I got through a whole year's supply from Lothian [Health Authority]. So when I phoned up and [they] said you can't have any more pads [I said] what do you mean what am I supposed to do? I've got all these people and there was a big fuss about it.

The 'fuss' from the Health Board, was not just financial, but again revealed underlying tensions surrounding the provision of drugs to this clientele:

But you couldn't actually get them to say that...They turned it back on me and said well if you want to. Effectively they were saying, if they're not [HIV] positive you can't prescribe for them [addicts] because otherwise why would you be seeing them? I said okay fine and they imposed it. As a consequence for a year you couldn't get drugs unless you were positive....

Clearly those that were HIV negative were more likely to stay that way if they stopped injecting with shared needles. The decision to discriminate between 'deserving' and 'undeserving' drug users on the grounds of whether they were currently infected, rather than likely to be, seems a mistake which had both personal and public health consequences. These reservations were rooted in policies that still sought obedience to drug laws and states of abstinence.

The system of appointments contrasted with the older system of the scheduled meetings with the psychiatrists. It had more flexibility, showed greater understanding of drug users lifestyles, with fewer confrontations over late arrivals: 'They get rollicked if they come on the wrong day but if they come on the right day we don't care what time they come'. This new approach began to make an impact on turn up and contact rates with drug users:

In '85 for every 3 appointments you booked one person turned up. By '87, which included methadone but not for everybody, we got it down to for every 7 appointments 6 turned up. We got it down to a 15% default rate from a 60% default rate.

Services such as counselling, further examinations, X-rays, blood tests and dietary advice were added, as they became needed and precautions were taken to limit the leakage of methadone onto the illicit drugs market:

We worked very hard to stop the stuff going to the black market including three or four days here where we actually made them swallow it in front of somebody. So I've got protocols about how to prescribe to try to stop it, but also if it leaks out I'm not that bothered. In one sense I'm bothered because it creates a market but at least it's not injectable.

If it could be believed that methadone was being taken instead of, rather than in addition to, injectable drugs, then there may be a case for a certain amount of 'controlled' leakage. The policy on needle and syringe availability from this clinic was complicated by the fact that the staff were only giving out non-injectable drugs. This would result in the following type of exchange if staff were asked for injecting equipment: 'Yeah we've always given needles but the difference is, if you come to me and say can I have a needle then you get a lecture from me as to why do you want one, I'm giving you methadone'.

Even though needles were given the unit took its behavioural modification role seriously by maintaining a level of authority according to the logic of prescribing non-injectable drugs set out above. The logic proved flexible enough that if pressed it would fall back to the more important concern, where needles would be given out whilst not curtailing treatment. Instead the user would be confronted and encouraged to reflect on their motives for receiving such treatment. A policy of maintenance then initiated contact, sought to influence methods of drug use, provided a key to trust building and was a small but not unimportant way of 'rehabilitating' the user as the consultant described: 'When they first meet you they are suspicious of what you are up to, as time goes on they start to trust you and they start saying yeah I'll take some pills. I call it a form of re-socialisation'.

Working alongside this flexible re-socialising approach was a more basic form of behavioural 'training', in the background, relating to the patients' actual behaviour as

an in-patient on the ward. This regulation of behaviour is described in the following extract by the consultant:

You teach them how to behave in hospital.... In a sense what you're trying to do is to get them to behave like most other people and that's the goal. You are saying we'd like you to come into the ward and follow the smoking policy...and not swear at people. The absolute no-nos are things like we'd like you to not assault people... and not shoot up. So a lot of that was me saying you've got to behave yourself.

There were important differences with those of psychiatrists years earlier. The drug user no longer shared unhelpful and inappropriate accommodation with the mentally ill. At the RIDU they may not have felt ill but they were infected. Another difference was that the forced and monitored abstinence policy of the Andrew Duncan Clinic in the 1980s was replaced by a policy of maintenance. Indeed if maintenance could establish stabilised behaviour it was often seen as not worth the risk of a return to chaotic use by taking them off:

Now the thing I think you have to balance all the time, are the downsides worse than the downsides of being off? If you've got somebody who is very stable on methadone, doesn't dabble with anything else, ... The more dangerous situation is where you take somebody off who's totally stable and then they go mad, they go chaotic. I'm not saying to people my ultimate aim is abstinence. With HIV I'm saying if you want to stay on forever you can I'm not bothered, but if you want to come off we'll help you come off. I don't know that even if you haven't got HIV there's much of a difference.

Maintenance had evolved to underwrite one half of new policies of increased autonomy, through contact, stabilisation and modification (a 'safer self'), and only peripherally addressed abstinence. Edinburgh institutions, such as the RIDU, using practices that encouraged less risky behaviour regarding HIV infection not only protected the drug user but the blood supply of the population. This meshing of technologies of the self and wider technologies of bio-power (concerned with population morbidity) Foucault terms governmentality (Foucault, 1988a: 19), that in this instance was derived from within Edinburgh. The NHS Circular no.1987 (Gen) (6) (SHHD, 1987) affirmed the continued importance of ground-up control in the planning and development of drug services:

The assumption of responsibility by Health Boards for the administration of this support programme is consistent with the Government's view that the task of planning and developing services for drug misusers should be undertaken by those best placed to assess local needs (SHHD, 1987: 1)

Statutory/non-statutory funding would be channelled through local Health Boards rather than the Scottish Office. Maintenance had evolved to underwrite one half of the new policies of a safer self-responsibilisation. The second half, discussed in the next section, was the distribution of free sterile needles.

The Needle Exchange System: Prevention and Behaviour Modification Part II

In line with local pleas and the McClelland Committee's recommendations, three pilot schemes for the provision of needles on an exchange basis were set up in Scotland in 1987 (McClelland, 1986: 11). These services were located in Edinburgh, Dundee and Glasgow. The Edinburgh needle exchange located in Leith Hospital was the first to become operational on 9th April 1987. Two medical consultants with nursing support were housed in the Leith Outpatients' Department across the road from Leith Hospital. The presence of medical personnel was in line with the McClelland Committee's conclusion that 'distribution should be undertaken only in a situation where other advice, medical if necessary, was available and was accompanied by instruction on safe injecting methods, safe sex, etc.' (1986: 11).

The exchange facility was another elaborated strategy of the safer self providing clean works for used and information on safe injecting techniques and sex. Drug user resistance was perceived as minimal as they were being given clean needles, non-judgemental health care for a new and frightening terminal illness, essentially what they wanted. However there were critical deficiencies, imposed from outside, in the operation of the centre. With the exchange initially only open a half-day once a week handing out a maximum of three new for old needles per visit, only three sterile needles could be obtained per week. A service aimed at a habit that continued day and night all week round soon found criticism for such an unrealistic operational approach. Indeed the service attracted criticism both from those unconvinced that provision would bring genuine change in injecting habits and so only condone and make use easier, and also from those seeing the provision as too limited and unrealistic to prevent HIV spreading. Both these arguments were played out in local

newspapers and medical magazines, covered in the following two sections, and underlines the continued contested nature of local policy.

What the papers said

The two most prominent papers based in Edinburgh are the local *Evening News* and *The Scotsman*, a national paper with an East of Scotland bias. The content of both revealed the contested nature of these new strategies.

One *Evening News* article, based on a survey of addicts conducted by one of the voluntary organisations, asserted that ‘some of Edinburgh’s drug addicts are ignoring the threat of AIDS. They are still injecting drugs, sharing needles and not practising safe sex’ (Evening News, 1987c). This type of article reflects the concern over the effectiveness of the then two month old needle exchange and issues of proliferation such as whether more needles were being given out than returned. As one needle exchange worker whom I interviewed confirmed, this was a correct assumption:

Q. Did you have a new for old policy at Leith Hospital?

A. Yes oh yes.

Q. Did you get new for old?

A. Well ‘ish’. I mean the other thing, we were only supposed to give out three needles and syringes which was a load of bloody rubbish. So we privately used to give out a lot more.

The policy of prescription was also contested and its links and contribution to addiction and the illicit drug market. A few days earlier the front-page title had been “Lethal Cocktail Kills Addict” (Evening News, 1987b). The story told of a drug user who had died after consuming a cocktail of unnamed prescribed drugs and alcohol. From this the paper asserted: ‘Graham’s death has called into question the whole system governing the distribution of prescribed drugs to addicts, and has emphasised the need for a co-ordinated policy between GPs, hospitals and drug groups working throughout Edinburgh’ (Evening News, 1987b).

The layered criticism points more to the perceived lack of co-ordination rather than the policy itself. The article goes on to condemn the restricted service at Leith Hospital where needles are given out over a two hour period a week as being

unrealistic as 'It [drug use] isn't a 2 hour thing it's a 24 hour thing' (Evening News 1987b: 1). It's the organisation rather than the policy that is seemingly criticised. Articles oscillated between criticism of the new policies, to the censure of their efficiency, well into the 1990s. Counter-arguments were also given space ranging from David Liddell's argument for an extension of the exchange scheme's opening hours, and the possibility of opening other similar centres (Evening News, 1987e) to the consultant Phillip Welsby's radical argument that called for the supply of heroin for drug users: 'It is paradoxical that we are advised to supply clean needles and syringes when we let the drug abusers buy the rubbish they inject from drug pushers' (Evening News, 1987a).

Newspaper articles reveal that policies within Edinburgh remained contested throughout the mid-1980s and did not suddenly change to accept the threat of HIV. By the early 1990s the papers were hailing the exchange system as a success making favourable comparisons with injecting levels in 1987 and the higher figures in other regions deemed not to have such a good programme (Evening News, 1992, The Scotsman, 1992). Generally the papers attitude can be perceived as mixed reflecting doubts surrounding drug users and fears of HIV/AIDS. The issue of needle availability and prescription drugs aroused considerable controversy within medical practice itself reflected by the heated debate in *Edinburgh Medicine*, a journal for medical practitioners.

Needle Mania in *Edinburgh Medicine*

Some of the language used in these journal articles appeared more sensationalist than in the local papers. Under titles like 'Needle Mania' (McKee, 1988) and 'A Junkies Charter' (McKee, 1989) one contributor railed against these new initiatives in a 1987 editorial that presented the following scenario and opinion:

Heroin addicts will mug, shop lift, house break or prostitute themselves to gain enough money to pay a pusher for the mix of heroin that they intend to inject into themselves. The Health Board then supplies them with free disposable syringes and needles.....The rationale of the experiment is based on the assumption that heroin addicts are susceptible to reason whereas by definition they are not.....A city fit for heroin pushers - is this really the sort of society we wish to create? (McKee, 1987: 3).

Whilst such language was reactionary this in part may have reflected the fact that the majority of GPs' experience of treating drug users, at this time, was very limited, feeding unease and fears of 'State opium parlours' (McKee, 1988: 3). Scepticism of these unproven policies was enhanced by the perception that at least some users came only to supplement their supply of drugs thus encouraging increased use (McKee, 1989). In extremis the doctor, in some of these articles, became just another drug dealer. Worries here are more directly focused on the original issue of drug problems than wider goals of HIV prevention. Counter-arguments that could not be proved at the time continued to stress the need for urgency and priority, especially in Edinburgh, in this matter:

AIDS has changed the rules. There is no point in fighting a battle unless it is worth fighting and there is a good prospect of victory. The battle against IVDA is worth fighting but we are certainly not winning and the aim now must be to minimise damage to society by any means that *seem* appropriate—we have no time to research until '*seem*' can be replaced by 'know' (Welsby, 1987: 9).

Once again, this time within the Edinburgh medical community, the local site can be clearly perceived as one where strategies remained contested long into the 1980s. Reinforced by regional statistics (previously mentioned) some contributors pressed for urgent action by addressing and informing a profession both ignorant about and silent as to the health disaster looming in the city. As articles like 'Or die of ignorance' (Greenwood, 1988) argued the choice and problems were not just for citizens and The Scottish Office but for GPs without whom policies could not be implemented. This was a push to get GPs to accept, share and more evenly distribute responsibility, framed in terms of HIV not drugs, rather than being ghettoised amongst the few as in past decades. Furthermore care should be shared, not centralised, between a co-ordinating Community Drug Problem Service and the individual's GP.

The Community Drug Problem Service: Shared care and comprehensive management

Drug use policy became further subsumed into the prevention of HIV infection in 1988 when the Community Drug Problem Service (CDPS) was set up. The CDPS was funded through money set aside for AIDS rather than drugs. The service started in

April 1988, one year after the needle exchange service started. Originally there were two community psychiatric nurses working with one consultant, with a social worker attached. The role of the CDPS was to give advice and support to GPs who would be asked to prescribe substitute drugs to users in their care. The CDPS would offer regular counselling to the drug user. Non-statutory drug projects were to be included wherever possible. Representatives of all these agencies would be included in the strategy of multi-disciplinary management of each drug user. Joint meetings would be arranged to decide on programmes of treatment. A short letter sent by the consultant to all GPs in the Lothian Health Board area in April 1988 facilitated acceptance of this proposed policy in Lothian Region. It consisted of two paragraphs, the gist of which is as retold below by the consultant when interviewed:

I just gave a one paragraph argument why we collectively had to just do something about this. My second paragraph was that as with every other aspect of psychiatry I would be expecting them to do the prescribing... There is no rule saying doctors can't give methadone but in all other places it was all centrally prescribed because GPs are frightened of drug users.

Thus in one instant GPs had been co-opted into the system and were now asked to be responsible for prescription and physical health of drug users. Care and management of drug use, at least in theory, became much broader-based within general practice rather than reliant upon a few willing GPs. General services were also tied into other non-statutory services that provided counselling, such as WEST, and with visits to the home by the CDPS. In 1990 involvement levels from practitioner surveys (75% response rate overall) found that half had or would prescribe and just under half would not (Greenwood, 1990: 588). By 1996, according to the CDPS consultant, 79% of practices (not practitioners) were involved with others that would but had no drug using patients. This still left 10-15% of practices refusing to prescribe ten years after the threat of HIV/AIDS was realised in Edinburgh.

The CDPS, in collaboration with the general practitioner and possibly a voluntary drug worker, would require an agreed contract with the drug user. The contract would cover the initial dose of methadone and a projected reduction schedule. There were additional conditions attached to the contract. These conditions were as follows; that the drug user should not demand additional drugs from their doctor; not sell the prescribed drug; continue to use only the prescribed drug; or fail to see the key worker

assigned to them. To back this up regular urine analysis would be included in treatment. The CDPS would be responsible then for monitoring, supporting and supervising the user's drug taking behaviour whilst the doctor prescribed.

Four types of treatment were offered in contrast with the more limited abstinence option of the previous decade. Of the 146 patients seen in the first year 68 (47%) were put on methadone reduction, starting on 30-40mg, decreasing by 2.5-5mg fortnightly (see generally Greenwood, 1990). Secondly 26% were put on methadone maintenance indefinitely, a measure for older users who had tried and failed in the past to withdraw and were deemed unlikely to be able to succeed again. Only 6 (4%) people were persuaded to undergo inpatient detoxification underscoring this options unpopularity. A further 23% were given counselling and support only, being seen as too chaotic to fulfil contractual obligations or where the doctor had refused prescription. Some users were lost to the system for imprisonment (6%), or being discharged back to the City Hospital (4%) or GP (4%). Of the 32 (21%) that lost contact with the CDPS 25 were in the counselling only option, suggestive once again of the adhesive nature of prescription. By June 1991 this wider treatment regime had seen 895 attending drug users (Greenwood, 1992). The number of people, in the long term, actually stopping prescribed drug use completely as a result of reduction is small. The distinction between those on reduction and those on maintenance is blurred as the consultant revealed: 'You see the ones on maintenance may suddenly decide to go down and the ones that are going down [on reduction] may decide to stop where they are. The number we get off are not a lot. I mean I would say it's less than 10%'.

This comment, made in 1996 by a consultant working at the CDPS, reflects the fact that in reality, policy is of a maintenance nature. That policy may not have been initially presented in such a way, and the reasons for this are revealed by the consultant's reflections:

When I started I naively thought, right we'll get them all in put them on methadone and get them all off. So that was what really sold it to the GPs, you know we'll keep people alive, we'll work with them, give them the counselling and they'll all come off. That was a load of bloody rubbish. I mean that was naïve, but it took the GPs with us because if we had told the GPs in 1988 that you'll still be prescribing for them in 1996....

The intention of policy here is seemingly a mixture of humanitarian care and continuing management of behaviour modification in a more autonomous environment of self-responsibilisation:

It is also a humanitarian way of working with drug users. I have to say if you have the choice between leaving people on the street floundering around in the criminal underworld....or going round to a chemists every day and being treated as human beings...I believe our counselling gets them to a position where they decide they want to come off drugs and I think they come off by themselves when they want to.

The local CDPS has had a significant impact on policy and reinforcing practices that encourage the drug user themselves to take more responsibility. Not only this but when asked how far the consultant would go along the line of the legal supply of drugs the following was recorded:

A. Well I'm going further and further along it. We're saying if you want drugs come and get them.

Q. Do you think that's becoming more and more acceptable in the GPs and the medical establishment?

A. Yes that's the one thing we have done in the last ten years. Now if you want it, have it, on your own head, it's your responsibility. I'm the gatekeeper to this stuff, but if you must have it then for god's sake don't commit crime to have it.

In turn this has led to a legal parallel supply of prescribed and proscribed drugs as the same consultant commented on:

A. We've diverted the law...and I do think we are very active competition to the dealers.

Q. It's almost as if you have replaced an illegal supply with a legal supply.

A. Well yeah although the depressing thing is that people still buy drugs on the street. We are playing a game really, because I'm saying you will have to get into being a real drug user then I will give you some drugs, and that is a bit hypocritical.

Whilst injected drug use remained a criminal matter, intervention and administration of drug use and users increasingly moved beyond the parameters of law. The most comprehensive expansion in management of, and services provided for, drug users came as a result of HIV/AIDS rather than drug use itself. Management focused on behavioural transformation of the individual, not necessarily to the point of abstinence; such a decision being more effectively and realistically taken by the drug user. Intervention, still at the local level, moved in part beyond law enforcement and abstinence. However the initial aims of treatment were in places, realistically or not, couched in terms of reduction. This additionally helped local GP participation.

However, as noted earlier, these policies realistically became characterised as ones of indefinite maintenance even amongst those supposedly on reduction programmes. Non-statutory agency reaction to this elaboration was mixed. Whilst increased resources were welcomed there were reservations that the concerns of HIV would detract too much from those of drug use. The continuing work of non-statutory, voluntary, agencies will now be analysed.

Non-Statutory Agencies and HIV: Liaisons with 'Safer' Technologies

The reaction of the non-statutory agencies to the provision of prescribed drugs and injecting equipment was of a broadly united nature. Most of the agencies did not attempt to directly provide injecting equipment, but became involved through facilitating access to needles through their contact with drug users. Most, where funding allowed, established an 'HIV/AIDS' worker. These posts were created to take account of the bereavement and grief and other issues that would impact on the people using their services.

Non-statutory agencies did not become part of any direct needle providing service for two main reasons. First, they felt that they should take an indirect role of initiating and supporting needle distribution as part of an attempt to normalise these services within the community. Secondly they felt that the services they had been offering, for upwards of ten years, were of a different and broader nature that would best be kept separate but complimentary.

Illustrative of the first approach was a project undertaken by WEST. This group liaised between a local pharmacist and the regional health board. The group, unofficially at first, obtained needles from the health board and supplied them to the pharmacy. Records were kept of how many were given and returned. This later became an open arrangement as policy became settled on needle distribution. The idea of a needle bus or similar facility for the area was resisted, as two workers explain, for the following reasons: 'I think partly to normalise drug use so that it was part of the community and the community's taking responsibility.....I think it was mainly a

positive approach through the pharmacy rather than something negative that we felt about needle exchanges’.

I think to get the community to realise it is part and parcel of life nowadays..... We didn’t want to hide the fact that a local pharmacy was giving needles and syringes. Treat people as normal when they come in. Because in a normal pharmacy you’ve got people coming in for all different things; their perfume, sanitary towels, they’re buying the whole lot and also you’ve got people going in either to pick up prescriptions or needles and not to make a difference between them and anybody else.

The indirect approach, through the community was the channel favoured for providing users with injecting equipment. It was seen as an attempt to normalise this type of provision within the community, where it could perhaps become more acceptable, rather than hiding it away. There was also a worry that these new statutory agencies would not be offering the broad range of services that the voluntary organisations were. Some of the voluntary organisations did not want to become part of this more, as they saw it, narrow provision:

They brought a van [a needle bus] and it was going to be parked outside [the voluntary agency’s premises] and I says ‘no it’s not.’ The important thing is it’s not just about clean needles it’s about health issues...It’s not about going to an ice cream van and buying a packet of fags and walking away.....I want[ed] a [fixed] stagnant site and I want it run with medics, I want it run with a counsellor and I want a nurse to be there.

Voluntary organisations saw themselves able to provide a range of services medical agencies had no interest in providing. The services provided by the health board, reflected a period transfixed by HIV/AIDS, focused on needle and methadone provision that appeared to need no extensive contact with the drug user. Voluntary organisations, formed at a time of greater concern with drug use *per se*, still perceived a need to discuss users other problems such as housing, employment and relationship issues by using the stock of local knowledge and responsiveness they felt unique. Thus the voluntary organisations wanted to keep the initial technologies of the self not just the safer self as one worker stated: ‘The harm reduction [CDPS] has helped in many ways in respect of the heroin, but drug abuse is still around. They feel that because it’s prescribed, that’s okay, it’s more controlled’.

Providing an alternative support outside the prescribing environment was sometimes hampered through the unconscious sidelining of the non-statutory agencies in the

referral process. GPs were seen by the non-statutory agencies as referring direct to the CDPS, with little input from other agencies. The only way into this process was seen as being through raising awareness of their existence with GPs and dealing with the surplus volume of referrals when the CDPS was swamped. The CDPS consultant saw the problem more in terms of the professional anxiety of GPs: 'GPs, medics, like to refer to medics. GPs insist on a medical viewpoint before they're prepared to prescribe'.

Increasing medical involvement over this period broadened the range of services for drug users, but in some ways narrowed the focus concentrating on HIV prevention. The technologies were still transformative in nature, but elaborated by doctors dealing with a more recognisable medical problem, a virus, that increasing numbers came to accept as a legitimate goal and one they could influence.

Behaviour modification and decline in intravenous drug use

Evidence of drug user behaviour modification, in terms of HIV prevention, was provided by a series of cohort studies conducted between the years 1986 and 1990. The Edinburgh Drug Addiction Study unit based at the West Granton Medical Group conducted this research. A number of follow up studies confirmed changes in 'risk taking' behaviour including a 1990 comparative study using a different cohort (Ronald et al., 1992). These tests revealed a large decrease in rates of drug injecting. The average number of intravenous drug injections per week fell from 20.73 in 1986, to 7.64 in 1987, and by 1990 had declined, in the second cohort (n=51) to 3.8 per week (see Robertson et al. 1988; Ronald et al., 1992). A similar decline was noted in figures concerning the number of episodes where needles were shared per month. In 1986 the average was 49.3 per month falling to 9.67 by 1987 and in 1990 the weekly average was 0.2. The average number of other people shared with per month fell from 16.1 to 3.2 in the years 1986-87. The increased use of oral drugs was confirmed, possibly as a result of greater access and heroin's much decreased availability (Skidmore et al. 1990: Ronald et al., 1992).

Other indications that injecting had gone down were apparent to a consultant at the RIDU commenting on patients seen at the unit:

We know we've got the injecting down a long way. Things like abscesses and all sorts of things and the fact the patients can't find blood [veins] anymore. You know when we started they were better at it than we were. Gradually we're better than they are. That's one of the markers I pick up on.

These findings provided a basis for the continued intervention of medical institutions in the field of drug use. Success was now being measured by these groups primarily in terms of behaviour modification and risk regarding HIV infection and not drug use per se. Although levels of abstinence were collected, they showed that only 19% were 'convincingly' abstinent by 1990 (Skidmore et al., 1990). The actual amount of drug use had decreased it was stated to a level where only 21% of the cohort used drugs weekly or more regularly (Skidmore et al., 1990). It was not made clear whether this included prescribed drugs or not. It was revealed in a study of younger more recent users that they were significantly more likely to use Temgesic, Dihydrocodeine and Temazepam associated as prescribed, or formerly, prescribed drugs (Robertson and Skidmore, 1989).

Evidence of the success of these policies was also seen as a vindication of the new approach to drug use that underpinned them. Risk reduction had overhauled the older policy of abstinence by proving that it could affect a broader base of drug users. Despite the reservations of some, it was seen to more realistically reflect both the intermittent nature of drug use and the fact that drug use of some kind was endemic to modern society. This new 'medical realism' can be seen evidenced in certain articles that take on an air of exhortation:

It is therefore unacceptable to 'write off' those who take heroin by adopting public policy which limits services to the pursuit of total abstinence, when this is neither appropriate nor possible for the majority in the short term...The reality of drug use and abuse, legal and illegal, presses on us these apparent contradictions. The message of 'safer drug use' is uncomfortable for many but in the present age is a reality (Robertson et al., 1989: 244).

This 'realist' message was based on earlier findings, discussed last chapter, that psychiatric based abstinence treatment was formed on an unrealistic assumption and unlikely outcome because drug use, legal and illegal, is a relapsing and remitting

practice. Others called for provision of the actual drugs taken and tentatively hinting at questioning the distinction between legal and illegal drugs (Welsby, 1987). For in a world that accepts harm reduction as the dominant paradigm all drugs that affect the nature of our state of consciousness fall under review. Comparative harms of drugs introduces a relativism that also questions the ability of legalistic boundaries to reflect the dangerousness of drugs that in turn ameliorates and deflects reservations over needle provision. Local governance within Edinburgh blurs arguments surrounding whether the state controls drug use, by accepting it, by appeals to pragmatic realism, priorities and what works. Again externally validated values surrounding drug use as deviance is replaced by different ones surrounding mortality and active self-responsible conduct. HIV necessitated a re-orientation in techniques to control intravenous drug use in Edinburgh. Local Drug Squad practices of needle confiscation slowly changed during the mid-1980s. Throughout the early 1980s and on until 1986 the Drugs Squad confiscated injection equipment. The way that HIV affected policing and vice versa will be analysed in the next section on the reaction of the Drugs Squad to HIV.

THE DRUGS SQUAD: From Repression to HIV and Ecstasy

Contradiction exists within police accounts as to what happened to the needles that were found. Such accounts are of considerable importance in defining the reasoning behind continued confiscation. It was this confiscation that restricted the supply of injecting equipment, and encouraged greater needle-sharing. Increased sharing created a growth in infections, commonly hepatitis. Tragically the most serious infection type, HIV, was unknown to all agencies until many had contracted it. Confiscation policy had dramatic, if unforeseen and unforeseeable results, with Edinburgh having the most alarming spread in Britain of any drug using community (Robertson et al., 1986a).

Many of the Drugs Squad officers interviewed said that they took needles away as part of the routine of evidence gathering and possibly the only remaining form of evidence of possession left, as one Drugs Squad officer recounts: 'We were taking needles away from folk left, right and centre as part of the evidence gathering process,

probably unaware at the time that what we were doing was causing more and more folk to share’.

However, there is an alternative account of what happened to the drug user’s injecting equipment. This appears in interviews both with drug users and a Drugs Squad officer. The police searching for drugs would often take drug-using equipment away from the user. One user describes what used to happen to his equipment upon being searched:

What would be normal for drug users if they did have a syringe or an extra needle you’d wrap them up in toilet tissue then poke it in like a pen and just put it in the top pocket and hang on to it like that. If you got searched and taken down to the police station the police found them. They’d just drop them on the floor and break them in front of you and you’d be like that ‘No come on, dinnae, it means I’ve got to look for all that and risk sharing with someone that’s maybe got hepatitis’. This is before AIDS.

One officer when asked gave a different response to the question of the reason for taking needles away:

Q. Collection of evidence including needles, what was your policy on confiscation of needles?

A. We would just take them out the house and bung them. Because it was nuisance value.

Q. Did you ever collect them as evidence?

A. Very seldom, very seldom. If we needed it as evidence the barrels would be examined saying yes there’s heroin in this there’s obviously been heroin used in this house....

Q. So it was mainly just nuisance value?

A. Yeah we were just being a pain in the bum to these people, take the works out the house.

Certainly much of the evidence collected for prosecution was minimal due to the difficulties already described in capturing people with significant amounts of drugs. However, the necessity of ‘taking away’ the users’ works is compromised further by the stated practice of Drugs Squad officers in the type of prosecution that was most often brought during this period. As described in the previous chapter, when discussing the harsher line on sentencing, in the courts, it was asked whether this was for possession or for supply charges to which, in this case, another Drugs Squad officer replied: ‘It wasn’t just possession. There was always a supply charge there, either intent to supply or concerned in the supply of, there was always a supply charge there of some description’.

In light of this practice it would seem the confiscation of needles was a superfluous form of evidence. Possibly the only reason for the collection of needles would be in

the cases of failed searches in shooting galleries where traces of drugs found in used works would provide evidence for a charge of possession. However, in some places of suspected drug dealing the tactic of crashing doors down in an attempt to get to the drugs before they were destroyed was not even attempted. The reason for this, apart from its inefficiency, was that the actual process of the selling of drugs was sometimes different. Instead of a 'shop and shoot' operation where the drugs would be bought and taken on the premises, they would be 'posted' through a strengthened door after the money had been deposited in the other direction. The collection of evidence could then change as described below by a Drugs Squad officer:

What we would do was we would park up in the vicinity, somebody watching the house, let people come and go away....Get them far enough away from the house and have teams picking them up and then finding and comparing analysis of the heroin [whether] it's a common source of [paper/plastic] wraps, fingerprints on the bags of people in the house and build up a case like that

Any confiscation of needles and syringes in this instance was again seemingly needless if the target was the dealer and not the user. The widespread confiscation of works, referred to above, seems to have a dubious utility in pressing for supply charges. Confiscation of injecting equipment can be seen as part of a continuing systematic attack on drug use at all levels, highlighted in the previous chapter, including a certain amount of informal harassment and deterrence.

Throughout this period the force area Drugs Squad had continued to target and arrest heroin users and dealers alike. The courts had likewise continued to impose heavy tariffs on those found guilty under the Misuse of Drugs Act 1971. The sentences that convictions attracted continued to be highly punitive. As discussed in the previous chapter high sentences were given even where small quantities were found and relatively minor offences committed (Woolman, 1985: 107).

The incarceration of large numbers of drug users and dealers continued during this period unabated. It was this level of imprisonment that left the police feeling confident that heroin was becoming less available (Lothian and Borders Police, 1985: 22). Whether this is the case or that heroin use had already peaked in its cycle of use during 1984, will probably remain an unresolved question due to the difficulty and

lack of continuing research done in the area around this time. By 1985 the Lothian and Borders Police publicly felt the problem was acute but contained (1985: 21).

What is certain is that the number of arrests for heroin possession and supply continued to decline during the mid-1980s. In 1986 police recorded that 190 charges for all (heroin) drug offences were made against 71 persons nearly half the number arrested in the previous year (Lothian and Borders Police, 1986). By 1987 only 23 persons were charged in relation to possession or supply of this drug (Lothian and Borders Police, 1987: 26). However a trend in the 'misuse' of synthetic opiate substitutes was noted during 1987 and 1988 (1987: 26 and Lothian and Borders Police, 1988: 21). The use of Dipipanone, Pethidine and Temgesic worried the police because these drugs were water-soluble and hence injectable. However at the time they were not covered by the Misuse of Drugs Act 1971 and thus possession was not an offence.

The impact of HIV/AIDS was recognised in the 1986 Report of the Chief Constable:

It is pleasing to observe that heroin misuse in Edinburgh appears to have passed its peak. While our policy continued to focus on the rigorous enforcement of the Misuse of Drugs Act, the spread of the AIDS virus was recognised as a major health hazard. The force is committed to playing its part in any legitimate initiative to help defeat this terrifying disease (Lothian and Borders Police, 1986: 2).

It should be observed that this commitment came at a time, during 1986/87, when the police were convinced of heroin's decline. What remains a subject of speculation is whether the reaction to the policies of the RIDU and needle exchange would have been similar if knowledge of HIV infection had coincided with peak usage in 1984. It has already been shown that the police reaction to hepatitis B infection, whilst not nearly so mortal, did not excite such a compassionate response. The reflections from Drugs Squad officers below on needle exchange give an indication of the unease with policy changes:

I can remember saying years ago in the police we don't believe there should be a free needle exchange and so on. I've got to say in this day and age I've changed my mind. I think the free needle exchange has its merits. While I don't agree in principle with it, I know the reason why it's being done. So I turn round to myself and say we were probably wrong in the early '80s through to about '85.

A. I think, well officially we were in favour of it. The Chief Constable and then each officer had his own ideas about it. In fact I think most of the guys who were seriously involved felt it was a good thing.

Q. Purely to prevent HIV?

A. Oh yeah purely from a health aspect

These reactions and eventual 'movement' was noted by the consultant at the needle exchange as well:

Well to begin with they were very ambivalent because they had, prior to that, been taking them away from people. They were concerned they were going to get needle sticks every time they searched somebody...The opposite happened to what they had thought. They lived with us that first year and I said, "Well look, what other choice do we have? If we don't do this would you rather they all died of HIV?"

This movement away from confiscation was reinforced by the statement of the Lord Advocate in relation to the facilitation of the commercial sale of equipment. This statement quoted below made clear that needle availability should be, within set guidelines, considered as not actionable for any crime:

The existence in Scotland of the common law crime of reckless conduct makes it impossible to say that the supply of needles and syringes to be used for injecting controlled drugs could never amount to the commission of a criminal offence. The Lord Advocate's view is that the crime of reckless conduct would only arise very exceptionally as regards the supply of needles and syringes by doctors and pharmacists and he would wish to retain a discretion to prosecute only in exceptional cases. While the Lord Advocate will not give any general and unqualified undertaking of immunity, he would not authorise the prosecution of any pharmacist in respect of the sale by the pharmacist of needles and syringes to drug misusers, provided the pharmacist has acted in accordance with the conditions and procedures set out (NHS, 1988: 2-3).

Despite this, there still appeared the odd reported occasion, even up to 1990, where there were complaints that this policy was not being followed. Minutes from a multi-agency called the Needle/Syringe Availability sub-group, clearly referring to less involved uniformed officers, noted as late as 1990 that: 'Works were still being taken from users on occasions by the police, other projects agreed that this still happened...It was felt that training of the beat officers was the key' (Needle/Syringe Availability sub-group, 1990).

By the turn of the decade Drugs Squad activity became centred on a different set of Class A drugs, Ecstasy (MDMA) and Eve (MDEA). A new cycle of drug use had started rooted in the rave scene and dance music. One Drugs Squad chief describes the change:

Yeah the problem had changed quite dramatically from you know 'smack city' which Edinburgh was in the middle to late '80s. We saw a dramatic turnaround in what was happening out in the street. Heroin which had been the prime drug of dealing back in the '80s had virtually disappeared...and the rave scene came along...

Most of the prescribed drugs were controlled by this time but many, such as Temgesic, Temazepam and Diazepam were only Class C. In 'user amounts' these drugs were not actionable, although of course what constitutes a 'user amount' is a rather subjective evaluation. Whatever the threat this trade posed, the Drugs Squad recognised that any leaks onto the illicit market from the CDPS prescription programme were more than offset by its potential to help control crime, as the following remarks from Drugs Squad officers confirm:

Because they got it for nothing it was handy. It was much sought after. Again I've got to accept that although it's a negative point from our point of view it was still positive. In the sense that there wasn't people going out screwing houses to get money for heroin and whatnot. Without a doubt it was an improvement and the force did subscribe to the CDPS programme and the rationale behind that.

They stopped stealing, they disappeared and we didn't come across them. We weren't needing to go round the houses because they were going and getting it from the programme.

Local Drugs Squad acceptance of change coincided with two important factors. Acceptance of HIV as the greater danger/priority accompanied a general police perception of the declining threat of heroin. Whilst injecting numbers dropped control was never relinquished, certainly regarding dealing in prescribed drugs, but concentrated on the later emergence of other Class A drugs such as Ecstasy. The rationale of both HIV prevention and the beneficial effects that drug prescription may have had on crime reduction were accepted, but perceptions of drug use outside those medically sanctioned changed little. The present chapter will conclude with an epilogue denoting some of the developments since the 'safer self'. The purpose is not to concentrate on the policies surrounding other drugs during the '90s, but to offer a brief sketch of the structure and location of policy formation that followed together with some of the problems arising as perceived by those involved.

Edinburgh Epilogue

This section provides an epilogue to the evolution of drug policies in Edinburgh during the 1970s and 1980s. The following sections analyse the strength of the ground-up approach in a more settled period for intravenous drug policy during the 1990s. Whether policy formation can be argued to be locally derived within Edinburgh is assessed in terms of the impact changes in the structuring, monitoring and contracting out, together with reports made during the 1990s, have had on drug policy in Edinburgh.

Awash with methadone: A regular contract

At the close of the 1980s the ACMD published its report 'AIDS and Drug Misuse' Parts 1 and 2 (ACMD, 1988). At the time the dangers associated with injecting heroin use weighed heavily in the drugs policy agenda. Part 1 of the report confirmed that the official aims of intravenous drug policy heavily reflected previous similarities between local practice and the McClelland report. The 'range of acceptable goals' was given as a cessation of sharing of equipment, the move from injectable to oral use, a decrease in drug use and abstinence (ACMD, 1988: 49). Fears of the spread of HIV from north of the border were far from unimportant. The well known mobility of Scottish drug users (noted in Chapter One) combined with the limited effectiveness of the pilot syringe exchange schemes (because of their limited opening hours) led to a prompt reminder of the consequences of failure when the report warned that 'HIV infection in Scottish drug misusers is not a problem for Scotland alone, it is a problem for the UK as a whole' (1988: 55).

Lothian Regional Council's Health Committee Report (LRC, 1989) expressed worries in terms of visibility when it stated that 'current estimates suggest that approximately only 40% of present habitual injecting drug users are in regular contract [sic] with services' (LRC, 1989: 4). This typographic error of contract for contact perhaps reflects the nature of the assumed relationship between agency and user. This was especially the case in Edinburgh at the time where service increases were based on the already discussed deal with users to protect themselves and others from HIV.

The Scottish Office summary memorandum report (Scottish Office, 1992) noted that heroin use in Scotland as a whole declined, certainly by 1987, (Scottish Office, 1992: 3) and additionally the number of heroin seizures in Scotland fell from 315 in 1986 to 108 in 1991 (1992: 41). However, multiple drug use involving prescribed drugs such as Temgesic and Temazepam (1992: 3) was noted together with a still far higher estimated rate of injecting drug use than the rest of the UK (392 per 100,000 compared with UK rate of 173 per 100,000 see 1992: 32). This it must be remembered was a national rate not an Edinburgh rate. The report noted that the prescription of substitutes, mainly methadone was still the source of much medical debate. Whilst the practice of prescribing was noted as widespread in Lothian it was 'patchy' in Glasgow and Tayside (1992: 31). Despite the growth in methadone prescriptions from 6,594 in 1988 to 51,244 in 1991 it can be surmised that certain areas, such as Lothian, were further ahead in these policies than others in Scotland. Thus even at the turn of the decade policy debates and outcomes could still be distinguished at a local level. This as we shall see later in this section was to have important effects regarding deaths from drug overdoses.

The HIV infection figures (per million) were still comparatively high. With London having a rate of 60 per million the figures in Scottish cities portrayed a dismal legacy with Edinburgh having a rate of 786 per million, Dundee 487 and Glasgow 147 (1992: 32). New fears centred not so much on heroin use as the developing prominence of the stimulant Ecstasy (1992: 35).

The national level response to injecting drug users remained poised between the need for enforcement and the need to contain and reduce HIV infection (1992: 5). This meant that drug users who also dealt, (or possessed an amount regarded as evidence thereof) remained within the ambivalent open-jawed framework of suppression and self-responsibility. National level debates surrounding substitute prescribing continued to reflect the distinctive and varying nature of local-level solutions.

Even within Edinburgh the policy of needle provision was far from seamless at this time. The Needle and Syringe sub-group of the local Joint Working Party on

Addiction noted in 1990 that gaps remained in Edinburgh, particularly in the Niddrie/Craigmillar area, where a permanent site for exchange had been slowed by the inability to obtain planning permission (JWPA, 1990). This area had few pharmacists involved in needle provision and had previously had the highest frequency of discarded equipment found by the Environmental Health Department. Figures analysed by the JWPA's Education/Information/Training sub-group in 1988 (JWPA, 1988) found that in a four month period there had been 46 occasions where discarded equipment had been found and removed for incineration. The number of syringes or parts of totalled 237 which was inflated by one instance of over 100 hypodermics being found, the mean average find being four. The Niddrie/Craigmillar area in this survey was the subject of 30 of those 46 removals. Any amount of discarded injecting equipment was worrying, but it may not have been of a scale that would have proved disheartening during a period of massively increased availability. During the early 1990s there were a number of local and (Scottish) national level reports that provided further confirmation that drug control policies in Edinburgh continued to be viewed favourably. This was especially the case when comparisons were made with Glasgow, but also highlighted that divergent local trends could even affect towns surrounding Edinburgh.

The difference location can make

McKenna's study of East Lothian (1993) highlighted the growing data that drug use was far from restricted to urban areas. Whilst the majority of those sampled used 'recreational' drugs such as cannabis, amphetamine and ecstasy, McKenna noted that some took opiates to 'come down' (1993: 22). Drug use was noted as being far from even, some towns being more heavily affected, whilst service levels such as GP support and needle availability were not comprehensive (1993: 19) later confirmed by Haw's (1994) study. Haw's research surveyed GP's prescribing practices in Edinburgh and the surrounding Lothians, together with a sample of Edinburgh drug users. GP's reported higher rates of injecting outside the city (1994: 7), whilst the drug user self-report data confirmed previously recorded low rates of daily (5% of users) and half-yearly (24%) injecting in Edinburgh (1994: 10). Haw's findings of low injection rates combined with reduced drug-related offending (1994: 15) provided

further support of both the initial research on the effect of the local Edinburgh approach and the policies themselves.

Haw also looked at comparable data from Glasgow that provided highly contrasting patterns of drug use in the two cities. Compared to Edinburgh's daily injection rate of 5% and half yearly one of 24%, Glasgow had a daily rate of 87% and 100% over the last two months (1994: 16). The drugs used most often by the Edinburgh sample were substitute drugs such as methadone and diazepam but those used most often in Glasgow remained heroin and buprenorphine, an injectable analgesic (1994: 16). Differences in the way users were controlled, and the ability to channel users into oral prescription, were reflected in imprisonment rates. In the six months prior to interview 52% of the Glasgow sample had been imprisoned compared to 16% in Edinburgh (1994: 17). Lastly, whilst drug overdoses can pose problems in correct identification, Haw estimated that Edinburgh had a fifth of the fatalities found in Glasgow (1994: 19). This seems to indicate that different strategies of control may exist in the two largest Scottish cities and that in a reversal of the well-worn phrase of the time, Glasgow was not miles better.

This divergence in drug deaths and control was emphasised in the ministerial task force report (SHHD, 1994) chaired by Lord Fraser of Carmyllie. According to police figures the number of drug-induced deaths in Glasgow in the years prior to the report had been 71 (in 1992), 41 (in 1993), and 48 in the first nine months of 1994 (SHHD, 1994: 59). Fatal drug overdosing in Glasgow at this time was the single most important cause of death among young adults. By comparison with Edinburgh the report noted that drug-induced deaths were four times as great in Glasgow which had only double the population (1994: 60). The main problem was identified as being that chaotic drug users were continuing to inject in Glasgow whereas there was less injection and chaos in drug use in Edinburgh. Whilst it was noted by the committee that the substitute prescribing policy had not eliminated drug use and fatalities in Edinburgh there was evidence that injected drug use, associated harm, street drug use and drug related crime had all been reduced as a result (1994: 62). This provides further evidence that locality can sometimes have a dramatic importance not only in the balance of techniques of control used but in the resultant influence on life and

death. The elaborated technologies of the safer self based on needle provision and prescription became a method of control much more fully embedded in and associated with Edinburgh policy than in Glasgow. Lesser investment in these techniques of a safer self in Glasgow resulted in injection rates remaining high, a lack of harm reduction and the more subtle control these technologies afforded even amongst those in contact with services. The reasons for this 'control deficit' lie outside the parameters of this research. It could however be pointed out that the response to intravenous drug use in Glasgow was historically much more firmly based in the statutory sector (as evidenced in the funding arrangements referred to last chapter). This in itself, as earlier stated, did not necessarily determine the approach to drug control. However, many of the services provided to drug users in Glasgow revolved around hospital-based psychiatry which has been seen to have problems regarding drug user resistance. Arguably the safer, subtler, techniques of control initiated by the non-statutory agencies and neighbourhood GPs provided an inherited policy around which the Edinburgh health agencies adapted their response to HIV that was missing in Glasgow. This may well have affected the latter's flexibility when it came to the implementation of measures such as needle provision and prescription. Indeed it was noted by the committee that it was only in that year, 1994, that Glasgow created its own version of the CDPS to prescribe substitutes, and that the committee additionally considered the 'Lothian model' as the national template of good practice (1994: 44). The committee emphasised this with regards to the comparative rates of injecting in 1993 with Edinburgh's said to stand at 6% and Glasgow's at 63% (1994: 44). Clearly locality still mattered.

Local Governance or Governance at a distance? DATs the Question

The report chaired by Lord Fraser was important for at least two other reasons. First it signalled at a national (Scottish) level, a change of emphasis away from a preoccupation, with enforcement largely welcomed by those interested in other approaches to control. Secondly it was responsible for bringing into existence a formal structure for the administration of drug policy. This was enshrined in its recommendations for the establishment of locally-based (initially on health authority borders) Drug Action Teams.

The key recommendations of the report contained within the Executive Summary are noticeable by their departure from the now predictable five point plan of international/national enforcement, deterrence, prevention and treatment. Instead the nine-point plan increasingly focused on prevention packages, effectiveness of drug services, substitute prescribing and associated services, diversion from custody and local structure and co-ordination (1994: viii-ix). This can be seen as representing not only a divergence from traditional state reports, but additionally signified the evolution of another distinctly Scottish direction in drug policy. In general the need to continue with prescription and needle exchange together with developing new services for recreational drugs (1994: 50) was encouraged. Additionally diversion even for possession of Class A drugs, which reversed previous Procurator Fiscal policy, was recommended so that decisions could be made on the basis of the individuals circumstances and offence rather than the class of drug alone (1994: 88). Linked to this was further encouragement to provide programmes for alternatives to custody (1994: 92). Within this lies a question surrounding the possible extent of non-statutory agencies' incorporation into the criminal justice system as a supplemental service in schemes of diversion.

Incorporation of another kind can, on an outline basis at least, be discussed regarding the establishment of Drug Action Teams. This new formal level of drug administration was formed under the following remit:

We recommend that, in each health board area, a small group of senior people should be established to draw up an action plan for tackling drug misuse locally and thereafter driving and monitoring its delivery. This group...should consist of senior local figures from the statutory and non-statutory agencies, including health board, the social work department, the education department, the police and voluntary sector (SHHD, 1994: 74).

It was not envisaged that the Drug Action Team (DAT) would have any executive powers itself, as the provision of services would remain with the existing agencies (1994: 74-75). However, it was to perform the key task of planning, co-ordinating and stimulating local action on drug policy. The DAT would be responsible for drawing up a strategic plan that could be said to amount to a combination of local needs analysis and local policy on drug issues that agencies providing services would have

to take account of (1994: 75). This responsibility went far beyond the simple description of ongoing work conducted by service providers. Although this was a central government initiative to establish and fund the DATs it remained somewhat unclear as to whom, if anyone, these teams were responsible. The relevant section reads as follows:

Although teams are to be locally based and not subject to central direction, we recommend that The Scottish Office should monitor their development, should receive and assess their strategic and annual operating plans and should use its good offices to resolve any difficulties which may arise locally (SHHD, 1994: 76).

From this it would seem rather hard to distinguish whether or not the monitoring of annual plans and the caveat of using its 'good offices' as intervention in the resolution of any local disputes amounts to responsibility or not. Clearly central government had reserved the right to intervene in the last instance presumably where local action had become bogged down in dispute, but this does not amount to exercised control. Monitoring of the teams' output, as we shall see later regarding contracting out, falls a long way short of implying control of its production. One DAT member commented that:

A. It was never clear until very recently. It's one of the problems I think of the task force report.

Q. So nobody really knew who they were responsible to?

A. No vaguely it might be public health policy unit or the Scottish Office generally but no one was asking for 'let's see your plan'.

Problems of accountability have seemingly been resolved by the publication of the Scottish Office paper 'Tackling Drugs in Scotland: Action in Partnership' (Scottish Office, 1999). The arrangements require DATs to compile a 3-5 year plan/strategic review. The annual planning cycle is a bi-directional structure between DATs and the Scottish Advisory Council on the Misuse of Drugs (SACDM) responsible to the relevant Scottish Minister. Draft Annual Corporate Action Plans, showing how the local plan is being met including a budget, are sent to SACDM in May/August with SACDM producing its Annual Review and Action Priorities on how national objectives will be met in November/December. DATs are expected to finalise their action plans in line with SACDM review by February (1999: 12). At first this structure seems a centralist shift strengthening the ties with Scottish/UK government albeit at a distance. Certain points reveal a contrary or unclear tendency. First, after

SACDM takes up to 3 years to read these plans it remains unclear what the feedback to, or possible revisions of, the local level will entail (1999: 11). Secondly within the discussion the local dimension is far from ignored. For example in discussing the SACDM annual review the report reads 'The DAT Corporate Action Plans will require to be submitted on an annual basis. They will then be fed into the Annual Review' (1999: 11). Just what part of, or how, the local plans are fed into the national plan remains obscure. Seemingly the local plans could inform Scottish and UK levels. This opaque local-national dialectic is present again when discussing both objectives and action priorities, the steps needed to achieve the objectives, as the following extracts highlight:

Scotland's Objectives need to be applied differently at each level of implementation of the strategy, and sub-divided as necessary, *in accordance with the locally agreed objectives of DATs, and individual agencies. Objectives agreed locally by the agencies for the commissioning process may again be different* (1999: 11, emphasis added).

As a result of the consultations for this document, they reflect a shared view at the centre and locally on overriding national priorities. They should heavily influence the distribution of national resources and the decisions of individual Drug Action Teams (DATs) and agencies on strategies and approaches. *They are not mandatory, since historic factors and local service priorities may also be relevant* (1999: 7, emphasis added).

There is evidence then that inherent in this policy structure lies a local rider at least, as regards implementation priorities. This local dimension is further reinforced by the admittedly fuzzy dialectic between objectives and the levels at which they are set. In addition another unknown factor is that of the procedure for dispute resolution between levels. Whether this would or indeed could amount to a simple dictum from the more central authority is again unclear as consensus is assumed.

There has already been disagreement within the Edinburgh and other Lothian DATs over funding priorities and allocation. Each agency remains responsible for its own fund allocation, where the police allocate money to drug enforcement as the health agency directs monies to statutory and much of the non-statutory sector. A truly corporate DAT budget would involve the difficult process of identifying not only drug specific spending of say non-statutory groups but the generic resources of drug squad and social workers. Obtaining this information is imperative as without an idea of the available resources there can be little informed judgement as to setting local priorities

and hence policy. It also implies that all the money should be put in one pot and allocated according to DAT agreement that may run contrary to, for example, the operational independence of Chief Constables and health authorities. What would happen if the police were asked through the DAT to provide more support for community prevention work than straightforward enforcement remains an interesting point. A similar problem has already come about where the Scottish Office allocated extra funding to drugs. The Lothian share of this was £460,000. Lothian has four DATs, Edinburgh, Midlothian, East and West Lothian. One non-statutory worker gives their version of events below:

A. £460,000 extra came to Lothian health that was their wee bit extra for drugs. That was very good that's fine, we had a discussion (non-stats) [and concluded]...to cut a long story short it was supposed to go to the DAT and they were supposed to divide in line with the strategy...The health board decided that they wanted this and that and the other so £60,000 went to the DAT for their strategy.

Q. So where did the rest go?

A. The rest went to the health board it went to extra money for GPs working with drug users. So what the coalition of drug agencies have said is that we're not participating, we're not putting inputs in because it is a mockery.

Another member of a local non-statutory agency describes their frustration:

The process was good that's why we are so pissed off just now because everyone says it's a partnership we work together we prepare the strategy together we sit on the planning team together fine along comes this money, they talked the lie of a partnership...It was a paper partnership or a very limited partnership.

Another interpretation was given by a member of the health board who sits on some of the local DATs:

They (non-stats) feel that all this is rhetoric, we've reverted to type. I would say we are trying not to revert to type. When the money came through it had an executive letter attached to it saying this is for treatment and care. It wasn't connected in any way with Action in Partnership explicitly in the letter. Necessarily in these large organisations with large budgets there is horse-trading around what's going to happen. Where I think they have got a point and where I probably agree with them is that there is no explicit mechanism for prioritising.

Funding disputes reflect wider tensions between policy agendas, national or local, and what actually happens on the ground. The reality of policy, as previously seen, remains heavily affected from the ground up in this case local institutional resistance to corporate control. Horse-trading between local institutions may provide a back channel for policy arrangements, whilst corporate action is endured, creating a

mixture of the formal and informal. Both suppression and self-responsibilisation may continue to be locally balanced either formally or informally maintaining a level of autonomy regardless of the documents at any level.

Policy formation and local governance has shifted from one evolved from an informed ad hoc local setting with national acceptance of on the ground conditions and competence. Its replacement is an attempt at greater formal co-ordination in local decision making, organisational relationships and integrating the city with UK and national levels. In Chapter One, John and Cole's 'urban regimes' was defined as inter-organisational, sustained, co-ordinating and empowering decision making characterised by horizontal relationships between public/private elites (John and Cole, 1998: 387). Edinburgh drug policy in the eighties and into the nineties may have lacked some co-ordination, but with the exception of 'empowerment' it seems the latest local arrangement moves closer towards a process resembling an 'urban regime'.

The difficult question the last two passages have edged towards is the significance of the latest structure for policy formation between local/state levels and whether it is a move towards statist centralisation. There is seemingly a degree of both greater vertical integration between local and national policy sites and a strengthening of sustained urban local regimes, combined with a certain amount of institutional resistance, at the ground level. With each DAT acting according to localised priorities, with plans scrutinised over three years, the situation seems ambiguous.

Policy formation was further transformed by a new regime of funding. When Scottish Office direct funding to local services ceased in 1987 local health authorities took over this administration (SHHD, 1992). This represented a re-configuration of local governance between local statutory and non-statutory agencies. Specifically mentioned in the NHS Circular 1989 (Gen) 2 was an oversight requirement that 'monitoring and review arrangements should be developed' (1989: 3) including services provided, staffing levels, patient numbers/attendance and general performance assessment. This accountability has an important impact on non-profit (non-stat) autonomy:

Accountability is frequently understood to conflict with the autonomy of the non-profit organization, particularly because it implies some form of external control. There is considerable confusion about the concept of accountability...it means at a minimum, having to answer to those who control a necessary resource (Kramer, 1994: 51).

However, assessment is far from straightforward in its application as what is measured is often of limited value both from a planning or 'control' perspective as Kramer again reflects:

Typically, monitors place more emphasis on fiscal than on service reporting, and the latter is restricted to outputs (effort) rather than outcomes (effectiveness). Outcome evaluation is exceedingly rare and infrequently requested. Indeterminate technologies, ambiguous goals (e.g. prevention), and very short time limits are conducive to bypassing the complex issues of effectiveness (Kramer and Grossman, 1987: 41).

There are practical problems of just what is measured and its usefulness between balancing information on process (outputs) and more qualitative accounts (outcomes). There may also be a lack of priority in analysing returns from agencies. The Centre for HIV/AIDS and Drug Studies (CHADS) has a central role in the monitoring structure of non-statutory agencies for the health board that provides the majority of the agency funding. One of the workers there expressed the opinion that scrutiny was not particularly tight in the following interview extract:

Q. How do you measure what you measure, I know you get quarterly reports?

A. Yes we don't measure it brilliantly because it's the sort of thing that gets neglected when there are other things to do...There is a fair bit of benign neglect which up to a point the agencies probably like...when CHADS first started there was a system of self-evaluation three a year. Pretty ambitious and a bit of a treadmill for the researcher. Oh great another evaluation...Especially because they were mainly process focused....In '95 that had really started to break down....I think since then we have not done it satisfactorily would be my candid answer.

A System of monitoring drift, because of its boring and perceived small utility, is further compounded by difficulty of consensus of what good outcomes actually are in a field using differing treatment courses as the same interviewee explains:

It's a particular problem with the non-stats because they do so many different things and a contact with a person can be so brief or can be a lot longer. There is a tendency to compare them but they obviously have different styles and modus operandi.

A worker at a non-statutory agency confirmed the problems of definition when discussing one detail, outreach work, which is monitored in the quarterly reports: 'When you ask them to define what outreach is they cannot define it...They've no performance indicators yet'.

At the root of the discussion on monitoring drug agencies is the problem of just what should they show and the type of picture they should present, how indeed the drug problem should be presented as one CHADS worker discusses:

It's that thing, people expecting a sort of linear progress of things can only get better and obviously that's not true there's chronic relapsing conditions and all that. So I think in many ways that is true but that relates to drug use overall...But there are intermediate aims we do have a low injecting rate for instance.

This last sentence underlines the struggle that still exists over the definition of what is accepted or acceptable measured success. This has echoed from the eighties into the nineties over what it is that agencies succeed in doing. Definitions that were used last decade still prevail amongst agency workers today perhaps testifying to the continuing persistence of drug use. The definition of success given by one contemporary drug agency worker below echoes the stepped approach of the eighties:

I classify success as if somebody is chaotic and they become stable because you have moved them. If somebody is maintained and you are managing to maintain them that's a success as well because if they weren't being maintained they would have gone right back.

There is therefore a possibility of dispute and confusion between what agencies perceive their achievements to be and what monitoring may reveal. However, policy on monitoring is moving towards a much more appreciative anthropological and qualitative technique as indicated by the CHADS staff below:

One of the things I've seen the value of is a more sort of qualitative anthropological approach. So I'm not able to say 70% of users felt that it was a great service, but you do get a lot back saying the users are dividing into three groups of people who think this methadone has completely saved me, the other group think its a necessary evil I don't really like it but at the moment it's keeping me stable and other people saying well its just a system to be used.

The shape of local level policy formation may have changed not so much as a result of monitoring but because of the actual process of contracting services itself. Jane Lewis

(1993) in a study of health care of the elderly and the voluntary sector makes the point that such a relationship may cast the voluntary agency in the role of the supplicant rather than the partner. Due to voluntary agency reliance on funding from statutory sources Lewis argued 'statutory authorities, for the most part can both determine the shape of much of the voluntary sector and lock local agencies into the role of 'complementary' service providers (Lewis, 1993: 182).

This shoehorning of non-statutory policy into funding specifications was felt a tighter control on agency policy than monitoring as one such worker makes clear:

Well I think to me the lack of innovation of having a specification and you've got an amount of money and it's quite tight to meet those things. So the lack of being able to be innovative of being able to try new approaches that is what worries me.

However, apart from a certain stifling of new ideas the lack of any change in drug policy and techniques may be because of a period of overall quiescence regarding policy as the approaches have already been laid down in previous periods of time and other reasons as the same worker confirms:

It's come to a point where things have settled down. What you've got is people who want to maintain the status quo and people who want to maintain those jobs.

However, within this settled system changing perceptions and approaches to policy remains with those dealing with drug users at the grassroots rather than those commissioning services as the same worker makes clear:

Where does the work happen? You can have as many strategies or policies as you like, it's like me with a business plan. I can have the most wonderful business plan that I haven't got because it can be turned on its head by the people that walk through the door. It's about the people that walk through the door.

In a system in flux, not standstill, reacting to those that pose new or increasing problems walking through the door may well demand, again, a more ad hoc approach. Recent research conducted in England and Wales by Parker et al. (1998) confirms a new pattern of heroin use. The areas of greater use are the north-east and south-west (rather than the north-west of the eighties in chapter 3) and the methods of use predominantly mixed with 68% indicating that both smoking and injecting were used

non-exclusively. It does remain a disturbing historical fact that many that started smoking heroin in the eighties ended up injecting. The Tackling Drugs in Scotland report (Scottish Office, 1999) also highlighted the 'growing presence of heroin in Scotland with a 60% increase in new clients/patients in 1997/98 (1999: 3). Edinburgh agency workers' anecdotal evidence tends to confirm this return to heroin: 'Oh it [heroin] has made a come back down here. It's even better quality than it was when I was taking it. Some young people's first drug they are trying is smack'.

If Parker et al. (1998) are right that 'the spread pattern is unequivocally consistent with an epidemic picture' and a new cycle of drug use, the chances are that the first to react will be those at the local level.

This chapter has argued that whilst these policies were increasingly steered within statutory organisations they were done so within Edinburgh. They drew on initiatives in policy already established by predominantly non-governmental organisations (voluntary groups) in Edinburgh. This 'mixed' local site proved important in the evolution of policies relating to HIV and the elaboration of techniques of control initially deployed in the field of intravenous drug use. The adaptation of these techniques within a new policy setting, HIV infection and shared needle use, developed into a strategy that was utilised throughout Scotland and the UK. Thus it can be perceived that decisions within Edinburgh at the ground level surrounding provision of methadone and injecting equipment, based on a pre-existing set of developed notions regarding drug user provision, drove HIV policy in Scotland, and to a lesser extent the UK from the local to the national level. Locally developed technologies of the self became the operating system, transferred from the non-statutory to the statutory agencies, upon which HIV and intravenous drug control was largely based. Even the local enforcement agencies accepted to a certain degree this predominance.

Secondly, this chapter has shown how drug control policies became increasingly characterised by the deployment of technologies of the self, elaborated as a response to an urgent need to address the dangers of HIV. The evolution of these techniques was assisted by and in no small measure related to the increasing medical intervention

in policy making. The adjudged, overwhelming threat posed by HIV necessitated a response specifically aimed at practices surrounding intravenous drug use skewing drug policy toward HIV prevention. This was achieved through the utilisation of a particular set of techniques of the self that focused on the care and safer self as regards HIV, rather than addiction or harm caused by heroin.

During the nineties whilst the pattern of intravenous drug use may have diminished in Edinburgh it also however was entering into the surrounding small town environs. The effects of the recent re-structuring of policy remain for now rather indeterminate as far as the level of policy formation and techniques deployed are concerned. This ambiguity may unfortunately be resolved if there is a new increase in heroin use as some within Edinburgh fear. It must also be remembered that development of these practices in Lothian was not unique. Similar practices developed in other British and European cities.

The concluding chapter will argue that Edinburgh is not a unique case and that important similarities exist with some European and other cities in the significance local level governance has in drug policy. This will include analysis of how a local level site of policy, the 'Amsterdam Model', influenced the later national 'Dutch Approach'. Further discussion of the wider European dimension will focus on how this model has been adopted by a number of European cities that have formed a *bund* or confederation under a signed declaration called the Frankfurt Resolution. This opens up a new analysis regarding policy formation. So far the concept of policy formation has been studied in regards to the relative autonomy of the local site regarding 'statist' centred explanations. The cities participating in the Frankfurt initiative provide an example of another variant of local analysis, mentioned in Chapter One, of trans-local linkages. These linkages present a new horizontal configuration between local city/regional sites that supplements and complicates our understanding of policy formation. Additionally the techniques adopted within these local sites share many interesting similarities with the emergent techniques of self-responsibilisation so far discussed in the experience of Edinburgh.

CHAPTER 5

WELFARE NOT WARFARE: Dutch and European Techniques and Approaches

The central argument of this chapter is that the local level governance analysed in the specific case of Edinburgh is far from unique – and that processes in local policy development found in Edinburgh possess important similarities with policy development elsewhere in Europe. This chapter argues that local initiatives at the city level in the Netherlands have moved away from a punitive culture, and that the ‘Amsterdam Model’ has proved influential in national terms becoming adopted as the state ‘Dutch Approach’. The Amsterdam Model has also provided inspiration for other European cities and similar approaches have proliferated at the city level within Europe. It is argued that these trans-local linkages between cities, introduced in Chapter One, provide a depth to the analysis concerning the direction of the flow of policy. Secondly, with the emergence and deployment of practices that encouraged the drug user to take responsibility for their drug using behaviour, similar to those discussed in Edinburgh, it is argued that there is important evidence of a strategy different from a punitive crime control culture. Innovation from within the city not only offers an alternative to law enforcement-centred policies but to state competence in the management of drug control. A new policy area between cities, rather than between cities and states, further diversifies and complicates our understanding of control flows and policy formation.

The first sections of this chapter will provide an analysis of the constitution of drugs policy in the Netherlands from the beginning of the 1970s to the Amsterdam Model and Dutch Approach of the 1980s. This will be followed by a more detailed analysis of the European-wide Frankfurt Resolution of 1990 and the trans-local linkages it helped establish. Examples of city level policy initiatives that encourage drug user responsibility will be analysed in the contexts both of European and of the San Francisco Bay Area in the United States.

Drug Control in The Netherlands

During the period after the Second World War a small trade in marihuana developed in The Netherlands amongst United States soldiers on leave in the Netherlands and amongst jazz musicians. By 1953 possession of marihuana became illegal in The Netherlands. With the increase in recreational drug taking in the 1960s, there was recognition there that drug policies needed to be re-evaluated. Heroin use at the time was not perceived as a problem and thus not a major point of consideration. The Hulsman Committee¹, reporting in 1971, took a relativistic stance regarding the dangers of illegal drugs compared to legal drugs. It also prophetically warned of the dangers of oppressive control and the marginalisation that would be produced, as Leuw recounts:

Among the undesirable side effects they mentioned the amplification of deviance and marginality of drug scenes; the symbiotic development of vigorous and violent specialized police forces and (organized) drug traffickers as opponents in an escalating war; and the gradual undermining of civil liberties and the legitimacy of penal law. In short, this early report on modern drug policy reasoned that law enforcement against the world of illegal drugs would be costly, would fail to really control the supply, would make the social and health problems of drug-taking worse than necessary, would reinforce the growth of powerful criminal organisations, and undermine constitutionality (Leuw, 1994: 30)

The Committee recommended that in the Netherlands cannabis use should be legalised and other drugs accorded similar legal status but that trading should remain a criminal (misdemeanour for cannabis) offence (1994: 33).

At about the same time, a Working Group on Narcotic Drugs (known as the Baan Committee) was again primarily concerned with cannabis, recommending in 1972 that possession of minor amounts of cannabis should be made a misdemeanour, trafficking remaining a criminal offence. Such a stance, later implemented in the Opium Act of 1976, rested on a distinction between cannabis on the one hand and drugs with unacceptable risks on the other, with policy toward the latter remaining relatively unchanged (Scheerer, 1978: 578 note 2). However, generally the debate within both

¹ The Hulsman Committee, named after its chair Louk Hulsman, consisted of representatives from the police, justice, public health and social scientists. The report title was 'Option in Drug Policy'.

the Baan Committee and the Dutch Parliament went further than legislation and reflected an opinion that escalating criminalisation was not desirable or even the primary solution:

There was a remarkably broad acceptance of the central notion that the use of hard drugs is not a problem that should be controlled by criminal law. The members of parliament expressed an almost unanimous conviction that drug addicts should be helped or treated, and should not be targets for law enforcement (Leuw, 1994: 34).

Whilst having limited reference to opiate use these commissions began a change in what Rose (1999: 19) would term 'regimes of truth' or 'mentalities'. Ways of speaking the truth about drugs in the Netherlands implied a change in intervention and provision of a space in policy where alternative strategies could be developed. However, this model would not be developed centrally but instead at a city scale, most notably in the Amsterdam Model.

The Amsterdam Model: Graduated Self-Responsibilisation and Normalisation

The modern era of heroin use amongst Dutch youth started around 1965 in Rotterdam and Amsterdam (Swierstra, 1994: 97). By 1980 the number of heroin users in the Netherlands was approximately 25,000, of whom 8,000-10,000 lived in Amsterdam (Swierstra, 1994: 98). Significant differences existed from the situation in Edinburgh, with Amsterdam having lower injection rates of 40% (Hartgers et al., 1989: 571) and a diverse range of cultural groups taking heroin with roughly 40% being white Dutch, 30% from Surinam/South Moluccas (former Dutch colonies) and a further 30% of people from other European countries and in particular from the then West Germany (Van Brussel, 1996: 364). A series of increases, peaking like Edinburgh in 1984, (1996: 364) marked the epidemiology of heroin use in Amsterdam².

² At first (1971-74) there were only a relatively small group of roughly 150 using semi-refined opium that changed to heroin use (Van Brussel, 1996: 364). From 1974 the numbers increased due to the number of Surinamese (approx. 2000) who had become regular inhaling users of heroin. The last wave during the 1970s consisted of native Amsterdammers and foreign users from Germany, Italy, UK and Spain (Korf, 1994: 126).

Initially in the 1970s treatment came in the form of abstinence-led psychiatric services. Grassroots agencies that offered an alternative to cure-based models quickly grew and although able to attract clients, struggled to prevent misconduct and mismanagement (Plomp et al., 1996: 713-714). Despite this, in 1979 the Municipal Health Service instigated a system of low-threshold methadone maintenance facilities that would grow into a multi-agency/threshold Methadone Dispensing Circuit. By 1981 the service comprised of two mobile (bus) sites and four community methadone clinics (Wijkposten) all outpatient based. Daily doses of methadone were taken on site with conditions attached, such as registering as a user and the user agreeing to regular medical supervision by their GP. Staff would attempt to motivate the user to take a further step at the outpatients clinic by accepting counselling and urine/toxicological analysis. These services and a raft of social welfare provisions³ were estimated to have reached around 3500 users annually (Buning, 1990: 1249). The Methadone Dispensing Circuit was not the same as previous psychiatric services modelled on a basis of detoxification and abstinence. Methadone maintenance signals a key change from a logic of abstinence to one where patients were encouraged to take responsibility for themselves and make choices. Drug users were encouraged to regulate their use through the choice of taking substitute drugs such as methadone, by attending municipal clinics and by accepting conditions such as regular medical supervision. These services, together with counselling and toxicological urine analysis operated by 'means of the act of personal decision and the assumption of personal responsibility' (Rose, 1990: 254) discussed in Chapter One. Drug users were no longer an object of medical treatment upon which they were practised according to an external code of abstinence. Instead they were 'subjectivised', becoming involved in the process – 'the active and practical shaping of the daily practices of their own lives' (Rose, 1999: 179) – 'to constitute, positively a new self' (Foucault, 1988a: 49). This was a change to an internal code of self-help and practices on oneself. The qualities of

³ In addition to the drop-in centres and street corner outreach work, night centres were provided for homeless drug users. A system of 'aftercare' services for former drug users was provided in order to assist with the reintegration of the individual. These services included supervised housing, vocational and 'social aptitude' training and lifestyle adjustment assistance such as the provision of regular work (Wever, 1994: 70).

these new policies are quite distinctly those referred to in Chapter One as self-responsibilising.

Users were often referred to GPs whose involvement by 1981 was extensive with up to 200 (50%) of Amsterdam GPs handling 40% of methadone prescribed to roughly 1428 (20%) of all drug taking clients by 1993 (Plomp et al., 1996: 712). This greater initial involvement than Edinburgh GPs was at a higher, medium, threshold with referral upon condition that the user could show their use was already stabilised, that they could keep appointments and that they could manage their weekly supply of substitutes. Such basic social regulation has been characterised as, 'Regulation...to the ability of a person to manage their life so that destructive conflicts with society and social environment do not occur or are at least minimized and no needless health risks are taken' (Plomp et al., 1996: 713). This 'stepped' approach, from low threshold mobile clinics to referred doctors' surgery sought to replace heroin dependency by activity along a graduated acceptance of self-responsibility:

By linking the low-and high-threshold programmes in this way, it is expected that the addict will be stimulated to regulate their own addiction and organize their life in a better way, as a step towards rejecting the addiction on their own initiative (1996: 713).

It should already be apparent that the Amsterdam Model establishes that processes in policy within Edinburgh are not unique. What we see in Amsterdam is that the drug control policies that were being initiated in the 1980s were developed by agencies within Amsterdam itself. They were not policies initiated in The Hague and then implemented locally. They emerged from within the city itself in response to what people were seeing as the everyday reality on the streets. Methadone maintenance was not the only shared feature found in both Edinburgh and Amsterdam. The next section analyses the Municipal Health Service's provision of injecting equipment.

Technologies of Transformation and Evidence of Change: Intravenous Drug Users and The Needle/Syringe Exchange

Together with methadone dispensing, the lowest threshold of intervention was needle exchanges. The provision of needles provided the most researched evidence that when drug users were encouraged to take responsibility for themselves they did so, modifying their injecting behaviour and moving towards a 'safer self'. Needle availability dated from relatively early on in 1984 when drug user consumer groups, the 'Junkie Union' or ('Junkiebond'), attempted to prevent Hepatitis B infection from spreading. A year later the service was taken over by the Municipal Health Service (MHS), which distributed 100,000 needles in 1985, 700,000 in 1987 and 720,000 in 1988 (see Van den Hoek et al., 1989: 1355; Hartgers et al., 1989: 571). By 1989 there were 11 such locations in Amsterdam. A series of cohort studies conducted by the MHS on the estimated (2000-3000) of heroin users in Amsterdam that injected (Buning et al., 1986: 1435 and Hartgers et al., 1989: 571) between 1985-1989, provided strong evidence of transformation of injecting behaviour. Hartgers et al.'s (1989) study and follow up examined whether there was any relationship between participation in the exchange programme and reduction in risky injection behaviour:

Exchangers [drug takers who regularly use the needle exchange] less often find themselves in a high-risk situation (i.e. having drugs but no clean needle) than non-exchangers. Predominantly, they use their own needle only once, while most non-exchangers use it more than once. Exchangers also borrow used needles from other IDUs [injecting drug users] less often than non-exchangers: i.e. the injecting risk level of exchangers was much lower than of non-exchangers in both 1987 and 1988. (Hartgers et al., 1989: 574-75).

There were however still problems in contacting younger irregular and non-Dutch (predominantly German) injecting drug users. Van den Hoek et al.'s. (1989) study and follow-ups, which again focused on user behaviour, found a decrease in risky behaviour with no apparent increase in injection associated with needle provision. Van Haastrecht et al. (1991), examining blood samples up to 1989 found that only 7% (n=75) of Dutch AIDS cases could be linked to intravenous drug use as the sole identified risk factor (1991: 59) in stark contrast to Scotland and Edinburgh's experience. Again incidence of acute Hepatitis B, with a similar transmission route to HIV, fell from 48 per 10,000 in 1984 to 8.6 per 10,000 in 1989 (1991: 61). An

ethnographic study of a similar programme in Rotterdam again produced encouraging findings:

In 68% of self-injection events, a new syringe was used. In 23% IDUs reused their own syringe. In less than 10% of the self-injections, a potentially unsafe syringe [one that was found or received from others that had not been adequately cleaned] was reused (Grund et al, 1991: 1603).

Thus at an elementary, though important, level the measures of HIV prevention had to an extent produced a safer drug user. It must be remembered though that as Hartgers et al. pointed out, the counselling provided by the MHS operated at a higher threshold requiring a level of stabilisation (Hartgers et al., 1989: 575). This is in contrast to the drop-in centres in Edinburgh that deployed counselling parallel to rather than above methadone and needle provision. The Amsterdam Model was doubly successful in establishing contact with the majority of injectors and changing their behaviour, making it less risky as regards infection, although there is little knowledge on how much further they progressed. Again this initiative provides ample evidence both for demonstrating that policy originates from within the city and for the emergence and deployment of practices aimed at making the drug user more responsible for their own use. This ground-up realist applied model became the accepted and adopted national approach by the mid-1980s, briefly detailed in the next section.

From the Amsterdam Model to the Dutch Approach of Normalisation

It is argued in this section that both the pragmatic approach and the informing ethos or 'conditions of possibility and intelligibility' (Rose, 1999: 19) of the Amsterdam Model informed and were adopted at the national level. The pragmatic policies of Amsterdam found expression at the national level, in new regimes of truth surrounding drug use, revealed in the report of the advisory and co-ordinating body called the Interministerial Steering Group on Alcohol and Drug Policy. 'Drug Policy in Motion' (1985) sought a new coherence in drug policy by first breaking down the different problems associated with drug use (Wever, 1994: 63). The primary problem of drug use was seen as one of physical and mental dependence caused by the drug. Importantly the secondary drug effects referred to included the various problems

associated with illegality and those more social problems related to the drugs legal status. All these secondary problems, the report concluded, were seen as a result of prohibition (1994: 63). As Wever points out one side of drug policy is concerned with the problems caused by another part (1994: 63). The proposed compromise between a policy of a war on drugs and their legalisation was a pragmatic process of normalisation. This process according to Wever,

Is not aimed at total elimination of all drug problems, but rather at initiating a gradual process of controlled integration of the drug phenomenon in modern society. Pragmatic drug policy calls for a process of "normalization" which involves managing the risks of psychotropic substance use in society, rather than getting involved in futile attempts at its complete elimination (Wever, 1994: 64).

Engelsman describes this process of normalisation and its meaning for the future Dutch management of drug problems:

It is another way of looking at things, not by denying that drug addiction may cause severe individual and family problems, but by demystifying the popular views on drug use. Integration does not mean acceptance, but discouragement of use is not identical with criminalizing the consumer. This approach could be compared to the alcohol-and tobacco-control policies and particularly to Dutch policy on cannabis (Engelsman, 1989: 215).

Thus the integrative 'ways of knowing' overlaid and implied a similar deployment of practices, already in existence in Amsterdam's provision of needles and methadone, discussed by Rose in relation to other forms of conduct managed in this way, including smoking and alcohol (Rose, 1990: 237). Engelsman perceived this normalisation as an important turning point in national policy and mentality, and as being 'put in another perspective...from a realistic point of view, unobscured by moralistic colouring' (Engelsman, 1989: 215). Thus a harmonisation of reasoning evolved between the integrative policies of Amsterdam, that encouraged the drug user to become responsible for their individual daily practices, and the mentalities of normalisation that encouraged a more pragmatic process other than criminalisation. The states national policy aim was now to concentrate on techniques that enabled the drug user to change their own lifestyle in effect mirroring of the Amsterdam Model:

The 'Amsterdam model' gradually became a policy concept and was adopted by the national government to become the 'Dutch approach'. In 1985 for the first time it was promulgated in a national government memorandum which gave it an ideological and political justification.

Characteristic of the Dutch approach is the emphasis on public health and harm-reduction, rather than law enforcement. Consumption and possession of illegal drugs are usually not prosecuted. The focus is on problems, not primarily on causes, and the system is directed not to abstinence but to regulation of the addiction in order to stimulate the addict's ability to manage their own life (Plomp et al., 1996: 715).

It is argued then that policies originating from within the city that confronted the everyday reality of heroin use with practices aimed at encouraging the user themselves to take steps to manage their own lives and modify their own behaviour, regarding drug substitution and reduction of HIV infection, formed the major part of a national approach. To complete the Dutch perspective a brief review of the responses of law enforcement will follow in the next section. The issues surrounding policing were influenced from a wider national approach and whilst they may to some extent compliment the techniques used at the local and latterly state level this does not always prevent significant numbers of drug users being imprisoned.

Criminalisation in the Netherlands?: Dutch enforcement of drug laws

Stemming from the Baan Committee and following the Opium Act of 1976 Dutch drug enforcement has long featured two bifurcations, namely between those drugs with acceptable (cannabis) and unacceptable risks and between consumers and dealers/importers (Silvis, 1994: 45). The second distinction, involving prioritising drug suppliers (known as the principle of expediency), operates where prosecution of offenders is deemed not to be in the public interest. In relation to soft drug enforcement on the streets, the practice is one of non-intervention. This practice continues despite being a party to the Single Conventions of New York, (1961 and 1972) and the UN Convention on Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988. Although these treaties oblige criminalisation of both possession and supply the loophole used by the Dutch is that none of the clauses relate to enforcement, only legislation. Such latitude is partially extended to hard drugs:

The tolerance shown for use of and trading in soft drugs is partly extended to hard drugs (e.g. heroin or cocaine). Users of these drugs do not have to fear direct intervention by the police in search of drugs (1994: 40-50).

This differs markedly from policies pursued in Edinburgh described earlier. The perceived inter-related pyramidal landscape of drug use/supply brought little distinction in enforcement practice in Edinburgh. However such distinction in the Netherlands does become blurred as regards the funding of drug habits, in drug related crime, viewed as an unacceptable excuse. Keeping drug users out of the justice system remains difficult: 'A large percentage of the prison population is addicted to drugs, which shows that the Dutch intention to deal with drug dependants primarily outside the criminal justice system is not altogether successful' (Silvis, 1994: 50).

Additionally broad policing powers allow officers to search anyone in a place known for drug use (for example, in certain railway stations) although in practice this power is more likely to be used as an information gathering device (1994: 51). Thus whilst the stated practical enforcement is one of separation of activities certain operational measures may complicate and obfuscate this division leading to a wider criminalisation process.

An additional factor regarding enforcement relates to the unresolved importance of the Schengen Agreement and European integration. Signed in 1985 (1994: 49) much attention was given to the mitigation of some of the foreseen negative consequences of customs deregulation. This was combined with a move towards harmonisation in anticipation of future unification. It is within these articles, especially 71, that Silvis thinks the challenge comes to practice or enforcement (1994: 49). However when studying the crucial paragraphs 1 and 2 in Article 71 little in the actual wording points to such a reversion. Paragraph 1 refers to 'Compliance with the existing UN Conventions', something with which the Netherlands has always seemingly been. Perhaps the greater Dutch fear is the international level at which harmonisation is derived, namely one that is often perceived as dominated by the 'American Position' of prohibition/criminalisation (see Nadelmann, 1993). Neighbouring countries such as Germany continue to arrest large numbers of individuals through drug control laws known as the *Betäubungsmittelgesetz* (BtMG) (Fischer, 1995: 390). However by 1990 an alternative development was evolving in wider European drug policy. This development was not at a national level, but it was international in nature. Initially

signed by four European cities, the 'Frankfurt Resolution' sought to take the initiative in drug policy at a municipal, city/province level. Its point of departure was the principles of the Amsterdam Model and policies that motivated the drug user to manage their drug use less chaotically.

'The Submerged Continent in the Cities': The European Trans-localisation of The Amsterdam Model

This section and those that follow present two arguments. First, it is recognised that a number of European cities have established a trans-local network of drug control with an agreed policy agenda contained in the Frankfurt Resolution (1990). Policy formation, it is argued first, not only exists within cities but between them. The second argument is that there exists important similarities between the types of policies used (namely to stimulate the drug user to actively manage their use more responsibly) in Edinburgh and Amsterdam and in those promulgated in the Frankfurt Resolution. Evidence also exists that these techniques have proliferated in other European cities such as Frankfurt. The reality of everyday drugs policy acquired an international context where it could both express, and resist the censorship of, the concerns of those working in the city streets.

In 1990 representatives from the cities of Amsterdam, Hamburg, Frankfurt and Zurich assembled in Frankfurt to discuss the problems and policies surrounding illegal drugs and at the conclusion signed an agreement which became known as the Frankfurt Resolution. Within this resolution there are a number of bold declarations that radically depart from the accepted policy stance adopted by European states. Section 1 starts with the declaration below and continues by laying out the broad basis of the city-level approach summarised below:

1. The attempt to eliminate both the supply and the consumption of drugs in our society has failed.
2. Drug addiction is a social phenomenon, which cannot be eradicated by drug policy, but rather regulated and at best limited. For many drug users dependence is a transitional phase of crisis in their personal history that can be overcome by a process of maturing out of drug dependence. Drug policy should not impede this process but must rather offer assistance and support.

3. A drug policy which attempts to combat drug addiction solely by criminal law and compulsion to abstinence and which makes motivation for abstinence the prerequisite for state aid has failed....the fear of city dwellers, in the face of drug trafficking and acquisitive criminality is rising.

4. Drug problems are not derived solely from the pharmacological properties of drugs, but are primarily due to the illegality of drug consumption. Illegality makes drugs impure and expensive, and the dosage is hardly calculable...

5. Drug users live, for the most part, in large cities or gravitate to the cities because that is where they find the market, the drug scene and the facilities for help. Consequently, it is the larger cities which are primarily affected, but their influence on drug policy is modest and stands in stark contrast to the burden they must bear (Frankfurt Resolution, 1990: 1).

In the second section the conclusions as to the broad directions and priorities that drugs policy should follow included:

1... The maximum amount of social and health assistance must be made available when dealing with drug addiction and drug users, and repressive interventions must be kept to a minimum. Criminal prosecution should focus its priorities on combating illegal drug traffic.

Anyone who wants to reduce the suffering, misery and death must firstly free the drug addicts from the threat of prosecution simply because they use drugs. Secondly, offers of help must not be linked to the target of total abstinence. Help should not only be aimed at breaking away from dependence, but must also permit a life in dignity with drugs.

2. It is essential that drug policy distinguish between cannabis and other illegal drugs....

3. The distribution of sterile syringes to drug users and maintenance with methadone are important means contributing to harm reduction (Frankfurt Resolution, 1990: 1).

The Resolution concludes with what it considers as the necessary policies to effect the conclusions drawn:

2. That purchase, possession and consumption of cannabis no longer constitute a penal offence (Amsterdam model). Trade should be legally regulated. That the legislators and the national governments create the prerequisites for low-threshold prescription of methadone (Amsterdam model) and for medically indicated and scientifically accompanied trial with drug prescription. In this psycho-social assistance must be guaranteed (Frankfurt Resolution, 1990: 1).

The Frankfurt Resolution incorporates a very similar ethical and practical approach to the Amsterdam Model. It provides impetus for the preservation and expansion of the Amsterdam Model within Europe, and disestablishes criminalisation as the primary mode of drug policy on the grounds that it doesn't work. Divisions made in the Netherlands, between soft and hard drugs and users and suppliers, are re-iterated and abstinence is disavowed in favour of a gradual transformation of the individual through their own choice and with dignity.

At the end of the 7th General Assembly of ECDP (European Cities on Drug Policy formed to promote the Resolution) members in 1998 a further declaration was passed that provided a new basic policy document of the confederation. This Declaration of the ECDP 1998 (ECDP, 1998) was the document that new members would adhere to but did not replace the Frankfurt Resolution (see ECDP, 1999: 20). The Declaration followed the earlier Resolution when it stressed the need for a 'well balanced pragmatic policy...according to our local needs' (ECDP, 1998: 1). In addition to the three pillars of prevention, therapy and harm reduction a fourth, security, was added. Acknowledging the role of justice agencies in minimising harmful use was a pragmatic recognition of the possible needs of other, non-using, citizens of protection from open drug scenes in the city context. This addition should still avoid the marginalisation and increased health risks often caused to consumers by such policies (ECDP, 1998: 2). The ECDP soon expanded to include 31 cities/regions in 9 different European countries by 1998 ⁴.

It is Section 1 (5), perhaps more than any other that declares the important and independent realm cities inhabit regarding drugs policy. It draws attention to the fact that drug problems predominate neither throughout the nation evenly or at the state level, but are manifest and borne within the city in stark contrast to the influence granted them. The growing ability and willingness of cities to initiate and apply policy has been described by Marcus as 'The Submerged Continent in the Cities':

It is cities that are the theatre of this confrontation with drug addicts, where strategies are deployed and the social, ethnic and cultural developments appear that impose micro-strategies, dialogues among those involved on the ground, and the revision of deep convictions. Listening to the city and its developments means avoiding shutting ourselves up in fixed systems that are, unfortunately, associated with the central core of our States (Marcus, 1995: 291).

⁴ Signatories included Amsterdam, Rotterdam, Venlo and Arnhem in the Netherlands. Greece has 8 signatories, Chareloi (Belgium) and Innsbruck (Austria) also signed. Five signatories in Italy, including the Province of Rome and German cities include Dortmund, Frankfurt, Hamburg, Hannover and Karlsruhe. There are also willing proponents outside the EU Zagreb (Croatia) Ljubljana (Slovenia) and most comprehensively Switzerland (Basel, Bern, Luzern, St. Gallen and Zurich). Noticeably there are no adherents from Britain, France or the Iberian Peninsular.

Marcus focuses on the difference between national legislation and the compromise of realism in the cities that drives policies in a more pragmatic direction:

It is at the level of applying the laws that the war against drugs has, for some, been lost, whereas for others, the majority, it has never been declared. It is in this sphere that political objectives of eradicating drugs have rapidly been replaced by a pragmatic approach of controlling drugs and addicts, and that practices out-of-line with legislation sometimes appear, evolve and fluctuate, especially the boundary running through all our legislative systems between use and dealing, personal consumption and distributing drugs to friends...This pragmatism developed in contact with the reality of our city streets cannot continue to be censored and repressed (Marcus, 1995: 290).

Funken (1995) has defined this pragmatism of the streets as the participatory approach:

Non-governmental action in the field of the fight against drugs is marked typically by a participatory approach. This is motivated by the search for integrated or endogenous development of local contexts affected by growth in drugs...The non-governmental approach consists not in imposing a model of intervention from above or from the outside but in evoking responses to crisis situations from the local contexts themselves. Through a participatory dynamics involving local actors, primarily the populations directly concerned or targeted, NGOs develop integrated research and actions aimed at responding to the various problems met with (Funken, 1995: 296).

These extracts form part of a discourse that argues for the gradual displacement of central state policies and competence, in favour of alternative modes of governance submerged in the cities of Europe. The challenge to the lawful prohibition of drugs comes from the more recently deployed policies of 'self-responsibilisation' grounded in experienced pragmatism. These slowly evolving, emergent, policies rest not on the eradication of drugs and the drug user, but on their regulation, not on their repression, but on their transformation, not on their marginalization, but on their reintegration to the consumer society. Similarly the confession no longer becomes a tool of guilt leading to punishment and marginalisation but one of discovery, encouraging the self to make a gradual choice by way of resolution. Thus the power of confession lies not with distant laws but immanent pragmatism as Foucault explains:

The confessional discourse cannot come from above,.....through the sovereign will of the master, but rather from below,....Its veracity is not guaranteed by the lofty magistracy, nor by the tradition it transmits, but by the bond, the basic intimacy in discourse, between the one who speaks and what he is speaking about. On the other hand, the agency of domination does not reside in the one that speaks (for it is he who is constrained), but in the one who listens and says nothing;...And this discourse of truth finally takes effect, not in the one who receives it, but in the one from whom it is wrested (Foucault, 1979a: 62).

Through this 'participatory control' realistic approaches develop to what policy can achieve, reinforced through comparative findings actually found on the ground. Additionally, as Marcus argues, the research produced is not tied to considerations of official state policy:

Many exchanges have helped to begin sketching out common positions that show the limits to dialogue among States. But it is the quality of information that is the big surprise in these exchanges, as well as the feeling that this information is not being used to set the guidelines for national policies. This information can be used to give rise to co-operation projects...thus doing without information campaigns passing through central government, with their well known information blocks (Marcus, 1995: 292-293).

The building of NGO networks among professionals and cities/regions can be seen as a major challenge to State authority in matters of drug policy. The State's apparent inability to successfully devise long term policies of intervention in drug use is further challenged by the growing, independent, body of research, discourses and policies developed by professionals and cities. The experiences and increasingly spirited claims of success among the drug workers in the cities serves to further undermine the central state rhetoric and position on drug policy.

It is undeniable that at present the position cities find themselves having to take publicly on the question of addiction, considerably influences the position of governments. The latter face increasing difficulties in defining coherent, lasting intervention strategies. The fight against drug trafficking alone hides this incapacity of governments. The driving force comes from the cities, and the European dimension can and must play a major part (Marcus, 1995: 293).

One example of local level policy growth and trans-local linkages is found in Germany. The following section will argue that drug reform has grown at the trans-local level within Germany. Secondly, it is argued that initiatives, such as safe injection rooms, again reveal the emergence of the deployment of technologies of self-responsibilisation.

German Initiative and the Circle of Cities

The driving context of the city and its significance can be seen within a 'sub-section' of the ECDP operating amongst the German signatories to the Frankfurt Resolution. This group within a group is known as the Initiative Circle of the Cities and consists

of Frankfurt, Hamburg, Hannover, Karlsruhe and importantly a non-member of the ECDP namely Stuttgart. This sub-group has managed to incorporate as a spin-off a non-member city. Stuttgart, whilst not a formal member of the ECDP, has by joining this local German group affiliated itself to identical principles and practice that are also followed in Bremen. This alone is an interesting development in how other cities may be incorporated into local city networks.

In the West Germany of the 1960s drug use was associated with students and trainees (Weber and Schneider, 1998: 1094). Organisations such as 'Release' developed integrationist strategies including job projects and outpatient medical treatment, later described as harm reductionist. During the 1970s the Federal German government provided financial support that gradually replaced and undermined the Release approach by attaching provisions, including the employment of professional psychologically trained counsellors in abstinence only programmes. By the mid-1980s the changed composition and techniques resulted in a choice of abstinence therapy or imprisonment without syringe exchange.

State level drug policy continued to emphasise law enforcement and repression of drug use throughout the 1980s and on into the 1990s. However, a number of large cities in the north and central Germany, Hamburg and Frankfurt among them, began to develop responses that differed significantly from the state level. These metropolitan initiatives focused on an approach based on one of 'health and social problems' (Weber and Schneider, 1998: 1095). With a measure of general support from their Lander (local state government) an alternative drug policy evolved from the bottom up: 'Drug policy reform efforts in Germany are therefore locally initiated - this is especially so in that large cities have changed their attitudes toward a credo of 'living with drugs' or 'living with addicts' ' (Weber and Schneider, 1998: 1095).

Such city level strategies are far from pervasive, rooted predominantly in northern and central cities, in contrast to southern cities that continue the federal-approved approach. Weber and Schneider have explained this divergence in terms of differences of political allegiance the northern/central cities being associated with the more

'liberal' Social Democratic Party (although Frankfurt has had a conservative CSU mayor for two terms) with the conservative Christian Democratic Union predominating in the south (1998: 1095). This reveals a new perspective of political/spatial divergence within a nation both in terms of the type and level of policy formation.

The strategy of harm reduction in Frankfurt centred on a multi-agency needle-exchange network pulling in 'contact' agencies such as pharmacies, drop in centres, methadone programmes and homeless facilities. By the mid-1990s the strategy had expanded with the establishment of safe injection rooms (*Druckraum*). The aims of this provision were to cut down risks of HIV, other infections and overdose, provide another point of contact (for some who may not have been reached before) and the reduction of consumption in the 'open scene' (usage more or less in public) at the train station.

Uwe Kemmesies (1999) contrasted the work of the injection rooms with a survey of the 'open station scene'. Despite the open scene representing a somewhat extreme picture of intravenous drug use both samples of drug users surveyed made use of other drug agencies, but the injection room users made much wider and frequent use (Kemmesies, 1999: 23). The time span of the six month survey prevented any realistic comparison of HIV infection rates. It was data on overdoses that provided the most startling contrasts with nearly one in four (23%) in the open scene reporting experiencing this in the previous four weeks compared with just 0.2% over 2 months and 10,000 injections in the safe rooms (1999: 30). Use of the three sites/rooms was extensive with 10,609 injections in two months, a weekly average of 1,219 and 173 daily uses. Despite problems with the location of two sites and restricted opening hours these local initiatives made a significant impact in terms of numbers injecting safely/less harmfully producing a 'safer self' and scene. Fischer's study (1995) reinforces this message of city level health, effective distribution and the 'safer self', finding two thirds of injecting heroin users stocked one or more clean needles, and were less likely to share/reuse works (Fischer, 1995: 401). Significantly the

integrative approach has had an effect on enforcement with new levels of tolerance in the policing of hard drugs:

It is current practice in Hamburg or Frankfurt not to enforce the law against individuals carrying heroin or cocaine in amounts not larger than for personal possession, meaning dosages not exceeding the quantities necessary for two or three applications (Fischer, 1995: 397).

Changes in one dimension of control within the city can directly influence others. Thus in Germany the local/municipal level has provided the driving force for alternative policies to law enforcement: ‘harm reduction’ is best understood as a local movement, predominantly operating against strong legal and political resistance from superior levels of state control’ (Fischer, 1995: 390).

Further city-level development was manifested in a resolution, the Circle of Cities Initiative (1996), that followed the Frankfurt document, but was tailored for issues particular to Germany. The aforementioned cities called for both the recognition and expansion of these health or consumer rooms and, citing Switzerland’s initiatives, the advocacy of the controlled administration of diamorphine after pilot testing (see ECDP, 1996a). Due to this parallel but tailored evolution the German national policy landscape has become much more complex with statist practices and mentalities challenged in important regions.

Even within the bastion of the war on drugs, the USA, there have been smaller scale developments in alternative policy strategies. Only a few states such as Colorado, Hawaii, Massachusetts, New Mexico, New York and Washington, fund Syringe Exchange Programmes (SEPs) with these few schemes representing the major part of harm reduction strategy in the United States. Other states restrict access to syringes through laws prohibiting drug paraphernalia or prescription laws or both (Bluthenthal, 1998: 1153). Bluthenthal argues that as a result of this from the early 1990s intravenous drug use represented the largest group of new HIV infections in the USA (1998: 1148). Bluthenthal’s study focused on the struggle surrounding the launch and continued existence of a local SEP programme in Oakland, California. This was a locally organised volunteer initiative that ran into opposition with the law

enforcement model resulting in the arrest of some of the activists. Despite this the local coalition continued to grow in organisational strength and political acceptability. Bluthenthal argues that the alternative drug policy of harm reduction is rooted in the 'local' level: 'To understand the progress and failure of harm reduction in the United States, it is crucial to examine state [as in local state] and local conflicts over HIV prevention strategies' (1998: 1151).

The Oakland SEP continues to offer a service that provides a keen reminder of the importance of sub-national policy formation. One indication of this significance is the continued growth and acceptance of non-federally funded exchange facilities estimated by the mid-1990s to have grown from 37 in 1993 to over 100 by the end of 1996 (1998: 1160). A similar facility in the San Francisco Bay Area exchanges over two million syringes annually (1998: 1154). The absence and opposition of federal authority assistance to intravenous drug users in nine tenths of the United States meant that alternative initiatives often came from the local level as Bluthenthal states:

The failure on the part of federal policymakers to respond to the HIV epidemic among IDUs [intravenous drug users] created the need for activists, public health service providers, researchers, and drug injectors themselves to design and implement effective HIV prevention programs. Continuing federal failure will provide activists with opportunities to 'push the envelope' in a variety of ways, including more active and central participation of drug users in program design and execution, more direct confrontation with the assumptions of the 'War on Drugs' and the development of legal strategies and legislation which permits SEPs and deregulate other harm reduction strategies such as methadone treatment (1998: 1166).

Even in the country that has one of the most stringent drug law enforcement policies the sub-national site is a growing importance in policy formation and development. Moreover, for drugs policies the future of the sub-national policy domain is not only concerned with consumption as the following section argues.

Policy Futures: Furthering the local/international context

Funken (1995) points to the desire of some cities to establish a link between local consumer city contexts and the more global levels of production:

The international struggle against the production of drugs leads to the model of eradication or of replacing one (illicit) plant by another (lawful) one. NGOs, in participatory fashion... no longer focus their actions against the growing of opium or coca but on also bringing to the fore the economic, social, ecological and cultural conditions leading to the local expansion in illicit crops and their diversion to the international trade in drugs...the collective expertise of non-governmental networks has argued for the need to bring in accompanying measures to compensate for the economic imbalances of the world market. This...in practice raises incompatibilities with the general framework of the fight against production of drugs, dominated by the eradication model (Funken, 1995: 300).

Thus at different policy levels the failure of crop substitution/eradication has been questioned in the same way as abstinence and repression. Whilst the threat to this policy paradigm, heavy with UN support, remains peripheral, any further development could threaten total disassembly of the war on drugs. Funken also perceives that for Eastern Europe and areas south of Europe (the Mediterranean Basin) city level policies represent an important alternative strategy:

The East, who see Europe as the sole possible hope of an alternative to the predominant repression model that at present marks international co-operation in this area and considerably affects development (Funken, 1995: 301).

Recently in Britain there has been a growing discussion regarding some policies analysed so far and their possible future deployment. The Police Foundation (2000) Report, chaired by Viscountess Runciman, recommended the much heralded reclassification of cannabis from Class B to C (2000: 115) as well as moving Ecstasy from Class A to B (2000: 50). Less well reported was the recommendation as to changing the present unsatisfactory balance in the allocation of funding resources as between enforcement, receiving 62% of the total funds, and treatment, which receives just 13% (2000: 119). Of much more direct relevance, and more radically, were some of the recommendations of the later Select Committee on Home Affairs' (2002) Third Report. The Report made two interesting recommendations with reference to injected heroin. After evidence presented from representatives from cities such as Zurich, Toronto and the Amsterdam MHS, the Committee recommended the introduction of pilot schemes of safe injecting houses (2002: paras 184-186). Secondly, it recommended that there should be a proper evaluation of diamorphine prescription for heroin users (2002: para 178). Whatever the eventual outcome it is argued that current discourse in the UK is considering approaches, some derived from the city level, that places a greater emphasis on techniques of self-responsibilisation. These approaches

could potentially replace the 'little used British System of licensing' (2002: 190) with a more developed 'New British System'.

It is argued that the Amsterdam Model has shown that the significance of local level policy formation was not restricted to the experience of Edinburgh alone. Indeed the approach grounded in the experience of policy makers in Amsterdam ultimately became disseminated at a much wider national level. Not only this but the model of local innovation also became an international model, whose uptake in Europe took place not between states but between some of the cities of Europe. Both of these developments saw the emergence of similar policies noted in Edinburgh.

Trans-local linkages presented a different and, in many senses, competing set of policies and importantly a different site of policy formation. The creation of initiatives within European cities instigated a much more complex and subtle arrangement of drug policy. The approaches to and services provided for drug use diversified and to some extent fragmented within Europe. They differed not only in their working ethos and services but also in the trajectory of policy. Possibly the greatest importance of this organisation is the fact that it represents the most challenging reference point to the more traditional policies of repression and accompanying mentalities of drug use and its continued marginalization. The future not just of EU drugs policies, but perhaps that of the whole of Europe and more, are wrapped up in the debates over who shall lead and who shall follow, the cities of Europe or the nations. Marcus argues that the choice is clear:

That submerged continent has to be the guide in our exchanges and in working out our action plans at European level. This is a major opportunity to help in disclosing these practices, since the national framework may stifle such attempts and make them seem hazardous (Marcus, 1995: 290).

CONCLUSION

The Central Dilemma

For the greater part of the twentieth century the dilemma of how to deal with drug use has been, like crime control generally, represented as a problem exclusively addressed by the central state. This thesis, by presenting an analysis of the evolution of drug policy in Edinburgh, challenges current understanding of the formation of drug control and the state's monopoly regarding drug problems. In Chapter One two approaches to the interpretative analysis of drug control policy were analysed. It was explained that the first of these, the 'top down' approach, perceives policy as originating from, and as an instrument of, central state. By contrast ideas were presented of a weakening central state where sub-national networks expand (Mayer, 1992). The chapter argues that power can also be studied within local centres where its real effects are produced and that such ideas (Foucault, 1980a: 97) can be appropriated and developed to form a second 'ground-up' approach that more accurately reflects the way drug control policy evolved in Edinburgh. It is argued that in recent years there has been an increased sensitivity to place (Sparks et al., 2000) and 'local realities' within criminology, often disguised by notions such as globally organised crime (Hobbs, 1998: 418). In addition other Foucauldian ideas concerning concepts of self-responsibilisation (technologies of the self) were analysed in order to help characterise some of the emerging changes in drug control, where the drug user was encouraged to take more responsibility for their use.

Chapter Two began with a discussion of research methods and how the research methods selected would help investigate the research questions identified by the dissertation. The methodology was discussed in terms of how it was physically carried out, including how interviews were transcribed and later analysed thematically, and the more theoretical reasons justifying such a qualitative approach were examined. In particular the qualitative approach of using interviews provided a way of obtaining new knowledge in relation to certain Foucauldian concepts discussed in Chapter One. This provided the possibility of linking the empirical evidence to the theoretical assertions illustrated through the discussion in the sections that followed in the later parts of Chapter Two. Drug user reluctance to participate in

abstinence and detoxification schemes was interpreted as providing evidence of a 'resistance' that existed outside of political affiliation or state directed protest but capable of being possessed by a group of heroin users within a localised setting of the city. These resistant acts of abandonment of treatment also provided a way of explaining not just that abstinence policies are ineffective when applied to groups and individuals who don't want them but support the argument that the subsequent move to prescription maintenance was derived from within Edinburgh as a response to this resistance. Similarly the changes in policing policy regarding tariffs and bail conditions were formed where enforcement mattered at street-level.

Chapter Three examined the period of the greatest increase in heroin use in Edinburgh, namely the early to mid-1980s. It was argued that during this period the *ad hoc* community drug user support initiatives grew from the ground-up, creating local centres of power that were recognised in national level reports. The relative decline of psychiatric services within Edinburgh coincided with a new amalgam of GPs and voluntary organisations that used their local experience and research to introduce new ways of addressing the heroin problem. This coalesced with the emergence of new pragmatic techniques that aimed to encourage the drug user themselves to take responsibility for their drug use by counselling-reflection and offering drug substitution. This definitive movement in drug control policy within Edinburgh, using techniques which I argued could be interpreted as constituting a strategy of drug user 'self-responsibilisation', was matched by the intensification of older policies again initiated within the city, namely law enforcement. It was argued that such divergence highlights the contested nature of policy at this level.

Chapter Four analysed how Edinburgh provided an exemplar model of response, within the UK, to the crisis of HIV infection amongst injecting drug users and illustrated the strength and relevance of policy making within Edinburgh, and which had influence far outside the city. Additionally the emergent strategies that encouraged self-responsibility not only became diversified and elaborated to encourage safer individual drug practices within the new circumstances of HIV infection but also became increasingly the dominant priority in drug policy.

The central argument in Chapter Five was that the specific case of policy formation within the city of Edinburgh was not unique. Evidence exists of local initiatives within other cities, in Europe and elsewhere, such as Amsterdam. The development of policies contained in the Frankfurt Resolution provided evidence of both an extensive pattern of policy formation grounded within the cities and of trans-local linkages between them. The actual initiatives and policies that formed the Amsterdam Model and Frankfurt Resolution also possess similarities with emergent practices encouraging self-responsibility found in Edinburgh.

The starting point of this dissertation was a dissatisfaction with existing explanations of drug control policy formation in which this was seen as an area led by and formed at the national level by central government. The initial hypothesis was that to a surprisingly large degree one might find that key aspects of such policy could be traced back to *ad hoc* movements within a given UK city. It was argued that in the case of Edinburgh, the research evidence supported such a hypothesis. Testimony was presented from key personnel of the times, such as doctors and police, who were faced with an empirical reality of increased drug use, drug related crime and HIV, and had little or no guidelines but who still had to deal with this everyday reality - in the most pragmatic - and best way they could. Pioneering work has already established 'local governance' as a problematizing factor in deliberations on how and from where crime is controlled. Whilst writers such as Crawford (1997) recognise that community initiatives represent a significant change in crime control, they nonetheless views the central state as retaining and containing power at a distance. As was seen in Chapter One, in Crawford's case the position that central government retains control but in a less direct manner reflects an unease concerning issues of social justice and local governance, akin to Briffault's disquiet discussed in Chapter One (see Crawford, 1997: 296). This perceived legitimacy deficit is remedied only by government confronting governance in the interests of social justice (1997: 296). This dissertation has not attempted to address directly either the meaning of social justice or the policies that enhance or detract from it. However, in general terms it may well be doubted that government remains an exclusive repository of power that continuously acts in accordance with the values of social justice. Further, as Garland points out in his review of Crawford's study, Crawford tends towards an 'overwhelmingly negative impression...and leads him to underplay the positive, progressive possibilities that

could follow' (Garland, 1998: 518). Policies are often unfinished and evolve over time and Crawford is keen to point out that there is nothing inherently bad about them. Lastly, each policy field must be examined according to what is found there. There can be little doubt that national level policies in many parts of Europe and the U.S. have in the past stressed (and continue today to stress) punishment and oppressive measures of criminalisation that incorporate little in the way of social justice. In contrast, governance in some cities that have turned to harm reduction has a much greater element of social integration, which is not to say that it does not control and manipulate, but that it does so with greater concern to the often multi-marginalised drug user.

This dissertation has shown how various groups within Edinburgh dealt with heroin use over the 1970s, 1980s and 1990s and how their views and practices changed in a transition from one paradigm to another. These groups moved away from an abstinence, repression and punishment model. During the 1980s groups of medics and voluntary organisations, partly as a pragmatic response to a feeling abstinence didn't work, partly as a change in ideology in the medical profession who saw people could make choices for themselves and groups based in the community staffed by ex-users and community activists who saw the lack of reality in current measures, realised that they needed an alternative. Again this alternative response was further reinforced partly because the argument within medicine realised that heroin use was a lesser evil than the potential of a widespread HIV epidemic and thus clean needle provision was needed to stem it along with behavioural change. There wasn't therefore a single reason for this historical change but rather a number of issues coalesced and together brought about change.

The newer form of policy and thinking was based on a conception of the drug user as someone who could themselves be employed in solving the drugs problem – not by being 'objectivised' as an object of medical treatment upon which medical experts practised - but 'through being 'subjectivised' by being involved in the process and began to regard their selves and habits as ones that they could themselves help to improve and stabilise. Such a transition in the mode of governing, as we saw in Chapter One, has been theorised by Rose and others, who have argued that western societies have experienced and undergone profound and widespread organisational

paradigm-change in control of precisely this type – away from a disciplinary model centrally controlled – moving towards governing society by governing subjectivity (Rose, 1990: 213). It should be reiterated that this transition is not one from repressive social control to some greater liberal freedom but rather that the shift might be towards a greater, *more* controlling, form of social control. Even though control may appear to be less centrally directed, this alone should not deflect attention from the fact that there are still relationships of power, resistance and social control.

This dissertation then has advanced a relatively novel argument namely that new emergent practices sought to enlist the assistance of the drug user rather than imprison them. It was argued further that, by adding to Hobbs' perspective in relation to organised crime, we should always be attentive and study crime as a local phenomenon, and that whilst the drugs trade may have become a globalised crime, many aspects of the drugs trade and attempts at its control remain distinctly local phenomena. If the central authorities have been slow to address aspects of the reality, perceived in drop-in centres, surgery waiting rooms and the cells of Edinburgh, Hamburg or Oakland, then the opposite is true of the policy development that has been spearheaded by those on the ground familiar with the city streets and who must deal with drug users walking through their doors on a daily basis.

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